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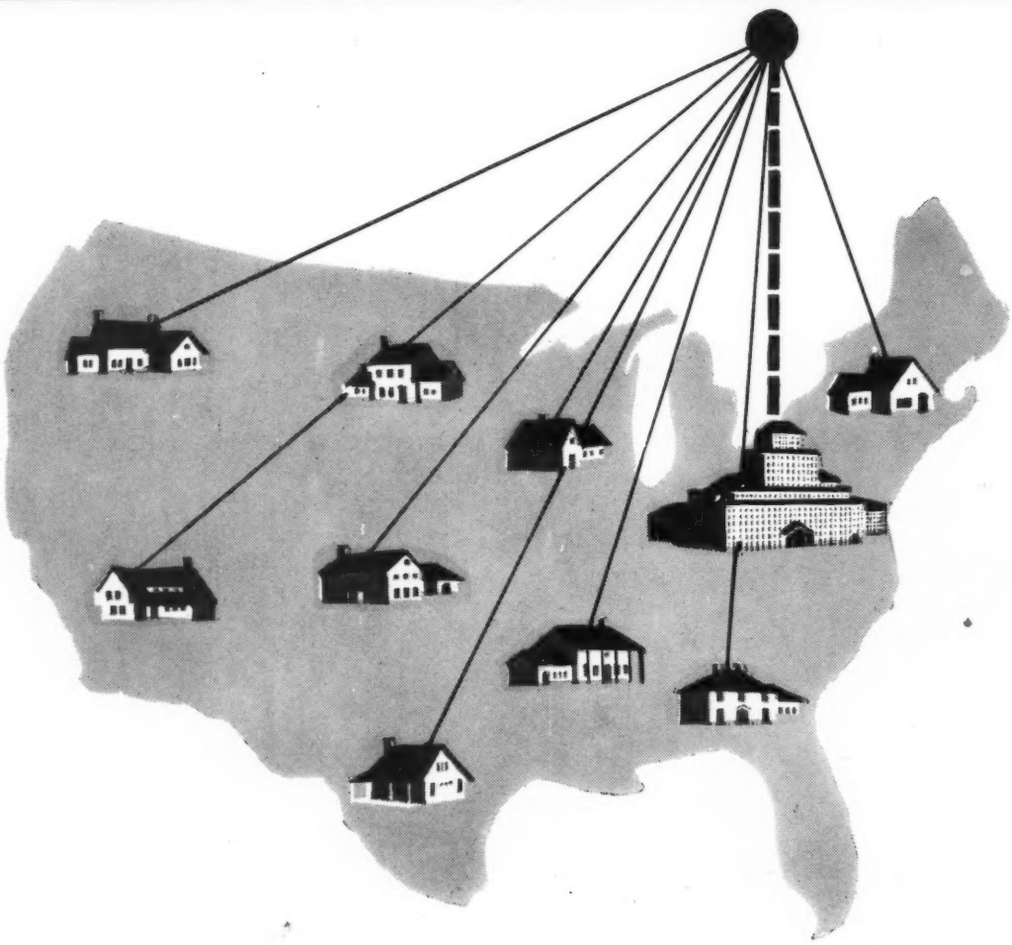
of the Michigan State Medical Society

Andrew P. Biddle, M.D.
MSMS President
1916-1917 and 1917-1918

JANUARY 1945

9 out of 10 cases of EPILEPSY are treated in the home



ERTRONIZE THE ARTHRITIC

To *Ertronize* the arthritic patient, employ ERTRON in adequate dosage over a sufficiently long period to produce beneficial results. Gradually increase the dosage to the toleration level. Maintain this dosage until maximum improvement occurs.

Ertronize early and adequately for best results.

ERTRON* alone—and no other product—contains electrically activated, vaporized ergosterol (Whittier Process).

Supplied in bottles of 100 and 500 capsules.

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CHICAGO

*Reg. U. S. Pat. Off.

ERTRON PARENTERAL

For the physician who wishes to reinforce the routine oral administration of Ertron by parenteral injections, Ertron Parenteral is available in packages of six 1 cc. ampules. Each ampule contains 500,000 U.S.P. units of electrically activated, vaporized ergosterol (Whittier Process).

ERTRON

Progressive Michigan Medicine

"The Michigan State Medical Society feels it a great privilege and honor to serve our medical veterans upon their return to civilian life," stated President A. S. Brunk, M.D. in his presidential message to the membership last month, when he outlined the State Society's newest and most progressive project—the Medical Veterans' Readjustment Program.

This program's threefold activity will assist medical officers with problems of (a) postgraduate work; (b) relocation; and (c) finances.

A counselor—a Doctor of Medicine—is to administer the program which was created by the 1944 MSMS House of Delegates. The project will be under the direction of the MSMS Council. Universal enthusiasm for this latest activity of the State Society in extending a hand of help as well as welcome to officers of the Medical Corps as they are separated from military service has been voiced on all sides by members of the medical profession on the home front.

The 1944 House of Delegates instructed that a per capita assessment of $5.00 be levied in 1945 on every active member of the State Society to defray the expenses of this postwar veterans' program.

MMS—Another Pioneering Project of Michigan

"In five years Michigan Medical Service, biggest voluntary venture into the field of medical economics, has become the nation's No. 1 set-up of its kind" stated the *Detroit Free Press* in a feature article on Sunday, October 15. 1944.

This professionally sponsored voluntary plan has proven to approximately 700,000 people of Michigan that they can obtain complete surgical service, including obstetrics and laboratory service, for themselves and their families when the need arises, without governmental intervention. And of the close to 700,000 subscribers, approximately 200,000 persons have received surgical services for which almost $8,500,000 was paid.

The Michigan State Medical Society spent thousands of dollars over a period of ten years investigating the possibilities of extending medical service to groups ordinarily unable to afford it. Its pioneering work and determination to serve the people has been rewarded by today's amazing results. Michigan Medical Service is able to insure complete payment of a subscriber's surgical bills for disease or accident for the modest sum of sixty cents a month. People sign up with their employer, church, club, farm cooperative, etc., in groups of ten or more.

Michigan Medical Service stands a most successful example of the medical profession's oft repeated contention that the people—who want medical security—prefer to obtain it through a voluntary program sponsored by the medical profession in whom they have faith. Michigan Medical Service represents five years of hard work, many worries and much heartache especially on the hardy and daring men who served and who are still serving on its Board of Directors. But the task has been worthy, well worth the grief of Michigan's medical pioneers. Their vision, determination, and labor for the good of the people are bringing forth fruit a hundredfold. The chief by-product of Michigan Medical Service is co-operation by lay groups in this and many allied endeavors.

Our Outstanding Postgraduate Medical Education Program

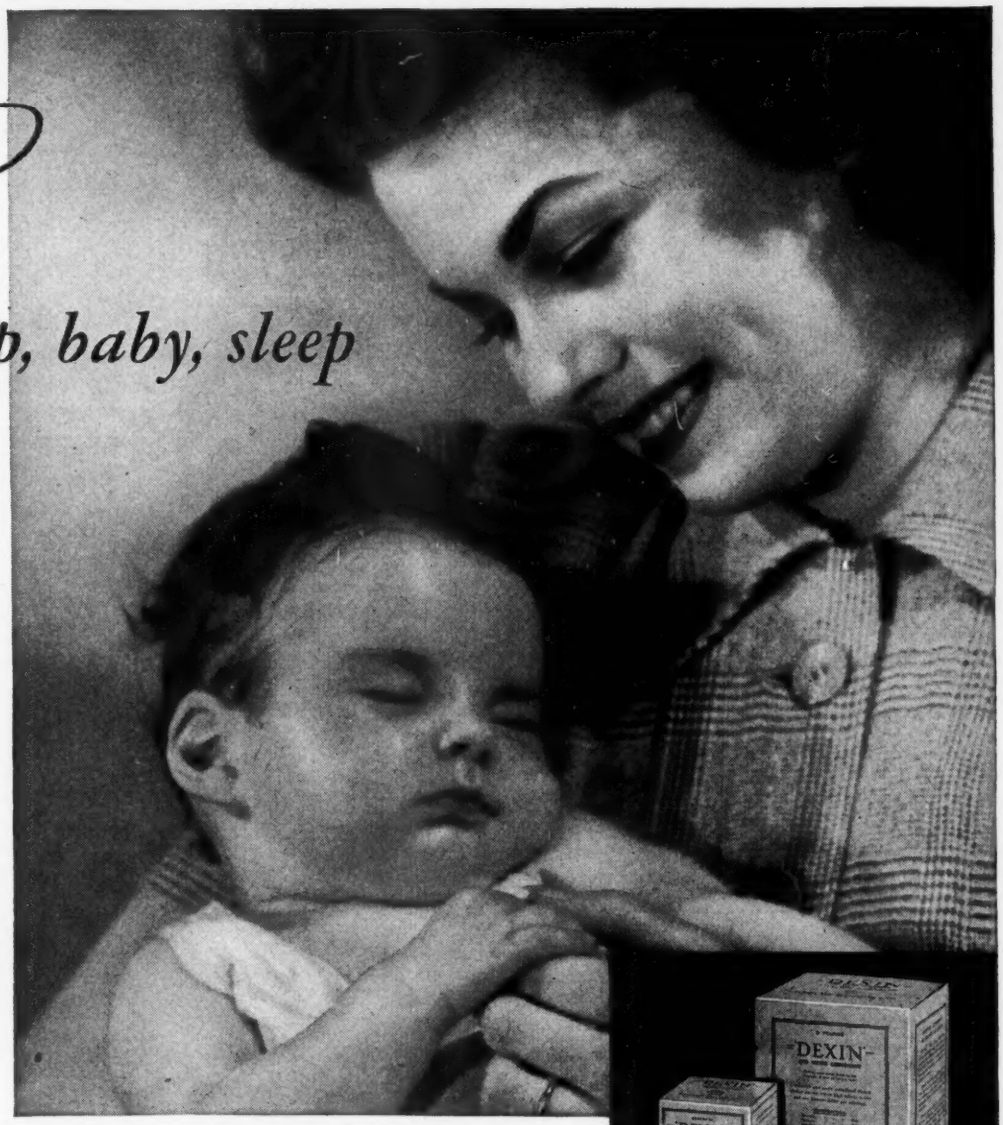
Another laudatory accomplishment of the Michigan medical profession has been its program of postgraduate medical education. Long ago, solid foundations for the present successful intra and extra-mural courses were laid by James D. Bruce, M.D., Ann Arbor, and the members of his postgraduate committees of the State Society. The fame of Michigan's "P. G. Plan," has spread and has been emulated throughout the land. Its work will be best appreciated in the immediate future, when our Michigan medical veterans return from military service seeking a continuation of their medical studies. The Michigan program is ready for this test of its ability and scope. Success and satisfaction again will be spelled out for Michigan's outstanding postgraduate medical education program.

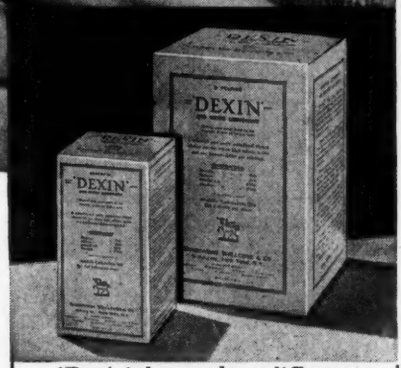
Radio Advertising by the Michigan Medical Profession

The purchase of time over the air to present a message about medicine and a "plug" for the medical profession and its philosophy would have been a revolutionary thought ten years ago. But the Michigan State Medical Society did this, to the tune of $10,000, in 1944. It presented two five-minute broadcasts per week, for 13 weeks, over twelve Michigan radio stations covering every section of the state. The 26 five-minute presentations were dramatized sequences of an educational nature. The theme of the skits depicted the benefits TO THE PUBLIC of the present and proposed medical availabilities as contrasted to federal or state bureaucratic compulsory forms of medical practice. Professional

(Continued on Page 8)

Sleep, baby, sleep





BABY has had a good lunch and is sleeping comfortably, thanks to the flocculent, easily digested milk curds produced by 'Dexin'. Nor is it likely that distention, colic and diarrhea will disturb baby's sleep, for the high dextrin content diminishes intestinal fermentation.

Mother is happy because 'Dexin' is so easy to prepare. It is readily soluble in hot or cold milk, and is so palatable without excess sweetness that baby takes other bland supplementary foods willingly. 'Dexin' gives mother extra time for herself. Containers of 12 ounces and 3 pounds. 'Dexin' Reg. Trademark

Literature on request

'Dexin' does make a difference

COMPOSITION

Dextrins	75%
Maltose	24%
Mineral Ash	0.25%
Moisture	0.75%

Available carbohydrate 99%
115 calories per ounce
6 level packed tablespoonfuls equal 1 ounce

'Dexin'

HIGH DEXTRIN CARBOHYDRATE

ACCEPTED AMERICAN MEDICAL ASSN

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
9-11 East 41st Street, New York 17, N. Y.

PROGRESSIVE MICHIGAN MEDICINE

(Continued from Page 6)

radio actors of high histrionic ability were engaged, the technical work being performed by a high-class advertising agency. Each sequence was followed by the following statement made by the announcer:

"American Medicine, the private practice of which represents the cumulative knowledge of decades, the heritage of centuries, the sacrifices and discoveries of countless individuals has made the United States the healthiest country in the world. Spinal meningitis, diphtheria, smallpox, typhoid fever, and other fatal diseases, scourges of yesteryear, are today either preventable or curable, a credit to the tireless efforts of the American Medical Profession. Thirty-seven states now have voluntary prepayment medical or hospital plans developed by the medical profession and the hospitals.

No theoretical plan, Government-controlled and operated, and paid for by you, should replace the tried and proven system of private practice now in use."

Michigan's experiment in advertising of the medical profession may have appeared revolutionary but it has been fruitful. Much good has been accomplished. Some of the people now know there are TWO sides to the question of distribution of medical care, and further, that the solution does not lie in the visionary panaceas offered by self-seekers or dreamers knowing nothing of medical practice, but in a thoughtful painstaking evolution being worked out by the medical profession of the United States. Many people now realize for the first time that private practice, aided by supplementary features—such as Michigan Medical Service with its 700,000 subscribers—are to be preferred, *for their own good* than more compulsion and further taxes out of Washington, D. C.

Michigan Health Council

When the Michigan Health Council was first conceived in July, 1943, even the sponsors did not envision completely the great and potent force for good which this organization has been and will continue to be. The Health Council is an educational vehicle, one that co-ordinates the necessary work of a number of agencies interested in ascertaining just what kind of health services the public wants, in procuring those services for the people, and in telling them how it is available.

An outstanding activity of the Michigan Health Council in 1944 was the Michigan Survey of Public Opinion, which verified the fact that the people look to the medical profession for guidance and action in the problem of complete distribution of medical care. The Health Council Survey mirrored the likes and dislikes of the people and indicated clearly how the medical profession could make itself into an almost perfect group, enjoying better public relations than any other profession, business or trade.

The future program of the Michigan Health Council, to which the Michigan medical profession lends its full co-operation, would indicate that this educational agency will be able to assist the medical men of this state to attain the goal of perfection indicated as necessary in the Michigan Survey.

* * *

Progressive Michigan medicine still strives for better things in behalf of the people it serves. It does not rest on its laurels. It seeks more progress.

ON THE RUN . . .

Excessive loss of potassium in chronic nephritis may result in episodes of flaccid paralysis of the extremities and low T waves in the electrocardiogram.

* * *

Patency of the ductus arteriosus after the age of seventeen is associated with an average reduction in life expectancy of about twenty-five years.

* * *

Wiring and electrothermic coagulation are being used successfully to inactivate syphilitic saccular aneurysms of the aorta.

* * *

Striking results in lowering toxemia, checking pustulation and effecting minimal scarring were noted in twelve cases of smallpox treated with sulfathiazole.

* * *

The application of a modified vanGieson stain (0.2 per cent acid fuchsin and a half saturated solution of picric acid in water) to a fresh burn after removal of the blister, has been suggested to determine the depth of tissue destruction. Living dermis stains a bright red while dead tissue takes up the picric acid, staining yellow.

* * *

A mild benign form of chronic hepatitis is likely after catarrhal jaundice.

* * *

Pernicious anemia is an extremely rare sequela to subtotal or total gastrectomy.

* * *

In nephritics, when the phenolsulphonphthalein excretion is below 5 per cent in the first fifteen minutes, survival for more than one year is unusual.

* * *

Multiple primary cancers of the colon may occur simultaneously or successively over a period of years.

* * *

Avian and mammalian embryos exhibit a much higher susceptibility to infection than adult tissues.

* * *

Extreme irritation of the peritoneum, as in perforated peptic ulcer, causes almost immediate cessation of all abdominal sounds.

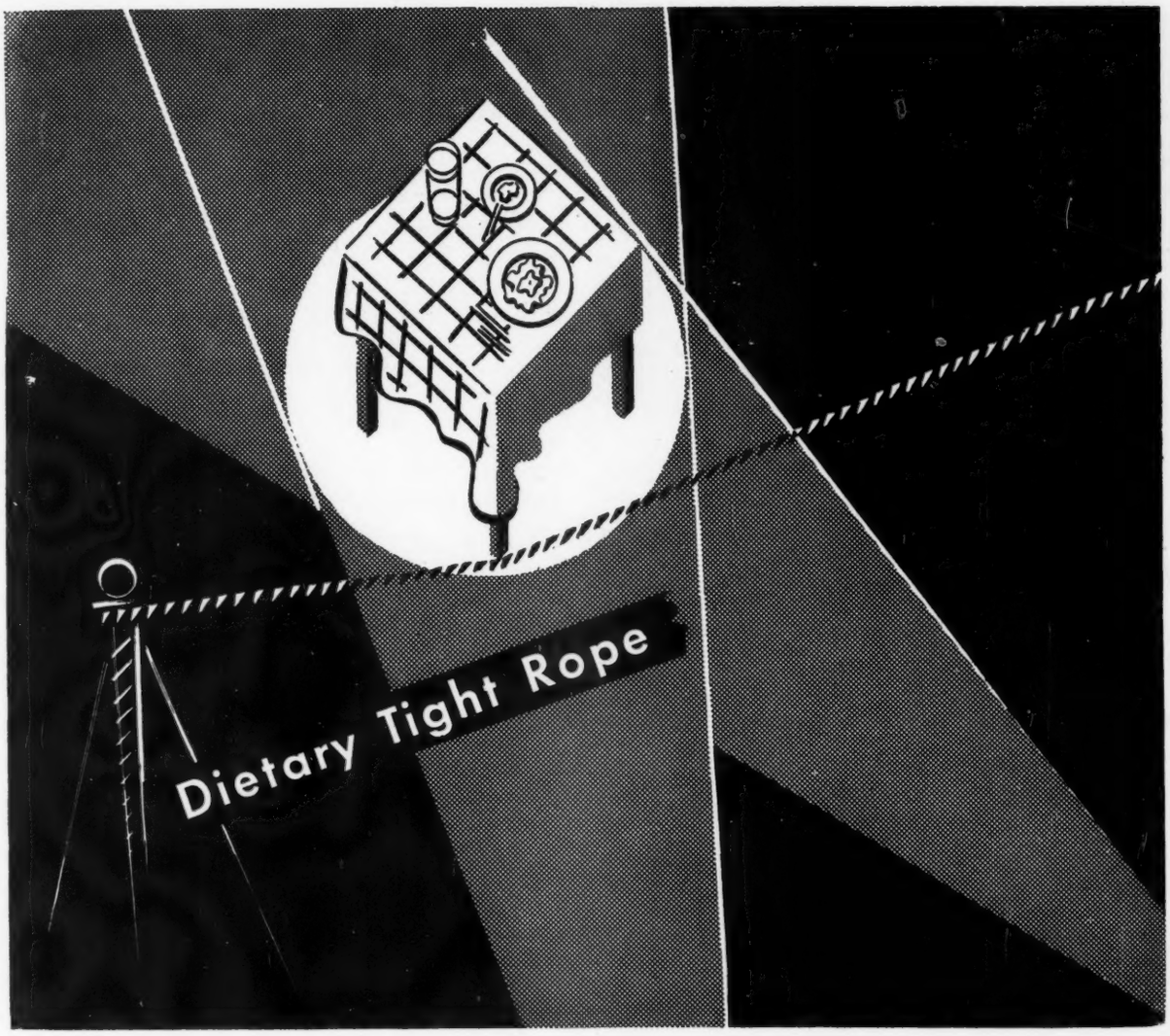
* * *

Children from six to nine years of age have exactly twice as many colds as children from ten to thirteen, and three times as many as those between fourteen and seventeen years of age.

* * *

A progressive diminution of blood urea has been noted in patients with acute or subacute uremia following the daily intramuscular administration of 2 to 5 mgm. desoxycorticosterone acetate.

Selected by W. S. Reveño, M.D.



The restricted therapeutic diet in metabolic, allergic, cardiovascular, gastro-intestinal, or renal disease may force patients to "walk the tight rope" of vitamin adequacy. Too often they lose their dietary balance, with the result that nutritional deficiency is superimposed on the primary disease.

An Upjohn vitamin product, prescribed with limited diets, often helps the patient retain a surer vitamin footing. One dose daily of the indicated high potency, economical Upjohn vitamin product is usually adequate for effective dietary supplementation.

UPJOHN VITAMINS

Upjohn
KALAMAZOO, MICHIGAN

FIGHT INFANTILE PARALYSIS . . . JANUARY 14-31

You and Your Business

THE MICHIGAN SURVEY OF PUBLIC OPINION SHOWS

QUESTION: If you were asked to choose, which would you prefer . . .?

1. Voluntary pre-payment program sponsored by the medical profession..33.7% (was the answer)
2. Government controlled...15.5% (was the answer)
3. Regular insurance.....13.4% (was the answer)
4. Payment for service at time rendered.....26.6% (was the answer)

When they know there is a choice, the people decisively favor a pre-payment plan sponsored by you.

Except That . . .

The survey also shows that three out of four haven't heard of *Michigan Medical Service,* sponsored by the Michigan State Medical Society.

QUESTION: Have you ever heard of a medical service plan sponsored by the medical profession?

No .....75.4% (was the answer)
Yes .....23.8% (was the answer)

It is a calamity that most of the voters of Michigan do not know there is an existing alternative to compulsory government prepayment.

SOCIAL SECURITY ON THE STATE LEVEL

Social Security proposals were not generally well received by voters at the recent state elections.

In the State of Washington a broad and immensely costly pension plan was overwhelmingly defeated. A ham and eggs proposition (known as the $60 at 60 plan) was decisively downed in California. In Oregon a scheme to replace old age assistance by retirement annuities and disability insurance was likewise defeated. Arkansas voted against a $5,000,000 hospital building program. In each case, cost to the taxpayers appears to have been the decisive factor.

From Massachusetts comes word that the advisory committee to the legislature, which has been holding hearings on health insurance for nearly a year, will recommend no action for the present. Continuance of the committee will be requested for the purpose of continuing its study when conditions return to normal.

Michigan an Exception

The trend to conservatism, cutting across party lines, has, however, some exceptions—one of which is Michigan. A broad social security proposal may come before the people at the April election. The measure is not soundly drawn and includes medical and hospital care. No predictions as to the outcome can be made until the situation has been further clarified.

Colorado is another exception—in that state a measure appropriating $1,500,000 for pensions of $45 monthly was approved by voters!

Of the four states taxing employes for unemployment insurance, in addition to the Federal tax on employers, Rhode Island already has a health insurance plan, there is no report of pending activity in New Jersey, and Alabama is said to be definitely under the control of an economy-minded administration. California is the fourth state.

* * *

CHICAGO MEDICAL SOCIETY SECOND ANNUAL CLINICAL CONFERENCE

The Chicago Medical Society is holding its Second Annual Clinical Conference at the Palmer House, Chicago, on February 27-28 and March 1, 1945. The sponsoring of this annual clinical conference for physicians of the Middle West has become an important function of the Chicago Medical Society following its inauguration last spring.

Chicago is a great medical center, probably one of the world's greatest, with abundant clinical material and clinicians of national reputation. The program presented at the first conference, last spring, was enthusiastically received by the several thousand physicians who attended. The Committee is already under way in securing speakers on important subjects for the 1945 conference. Exhibits, both technical and scientific, will be greatly increased.

BARUCH COMMITTEE ON PHYSICAL MEDICINE

The Administrative Board of the Baruch Committee on Physical Medicine has announced the granting of an additional sum of $185,000 for further advancement of the program in physical medicine and the physical rehabilitation of those disabled in the war. Grants go to seven colleges to establish continuing courses. Mr. Baruch was especially interested in the field of electronics as applied to medicine. Doctor Frank H. Krusen, director of the Baruch Committe announced that the Administrative Board does not contemplate any further large grants, but will turn its attention to the development of the centers already established. He stated that Mr. Baruch's gifts had served as a means of providing prompt co-ordination of the entire program for rehabilitation of our wounded, and for the provision of the trained personnel needed to activate this program.

CONFERENCE OF STATE SECRETARIES AND EDITORS

The annual conference in Chicago, November 17 and 18, 1944, devoted most of its energies to public relations. Talks were given by officers of the American Medical

(Continued on Page 16)

"another three ounces— just right, young man"

...A familiar statement by physicians prescribing Biolac for infants deprived of human milk.

The protein level of Biolac assures an adequate supply for growth and health, with small, soft curds. The adjusted milk fat facilitates digestion and assimilation with greater freedom from "fat upsets"; and the ample lactose content assures a soft natural stool formation. The adequate proportions of lactose, iron, and vitamins A, B_1, B_2 and D eliminate the need for time-consuming calculations of extra formula ingredients. Indeed, Biolac (supplemented with vitamin C) provides *completely* for infant nutritional requirements throughout the bottle period.

Easily calculated... Quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.

BORDEN PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE • NEW YORK, 17, N. Y.

Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B_1, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized, vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.

ACCEPTED AMERICAN MEDICAL ASSN.

Biolac—"BABY TALK" FOR A GOOD SQUARE MEAL

CONFERENCE OF STATE SECRETARIES AND EDITORS

(Continued from Page 14)

Association reviewing the work of the Association. Especial stress was made on the necessity for better contacts with Congress in the nature of furnishing information so needed in proper action on the numerous matters that affect the practice of medicine, and the care of the sick.

Plans for the postwar rehabilitation of the doctors in the military are going forward in quite detail. Rehabilitation of veterans is assuming major proportions of study and consideration. There is a broad program of rehabilitation and physical methods in a national Fitness Program that has sufficient financial backing and is just waiting for the spark from the medical profession that will integrate it.

Medical Service plans, and their essential place in the distribution of medical care are assuming more and more importance. Much of the discussion centered around this approach to the delaying of federal medicine.

Our own Andrew S. Brunk, M.D., President of the Michigan State Medical Society, spoke on Radio Broadcasting by the Medical Profession, and stimulated an active interest. Postgraduate medical training for postwar transition back to private practise was outlined and is being co-ordinated through a questionnaire sent to every man in military service, asking what kind of courses he wants.

1945 ANNUAL SESSION, MSMS

S. W. Insley, M.D., President-elect of the Wayne County Medical Society, has been appointed as chairman of the Detroit Arrangements Committee for the 1945 Postgraduate Conference on War Medicine—the 80th Annual Session of the Michigan State Medical Society—which will be held in Detroit at the Book-Cadillac Hotel, September 19-20-21. Twenty-five out-of-Michigan guest essayists, as well as a number of illustrious Michigan speakers, will be on the 1945 program.

Harry F. Dibble, M.D., Detroit, is chairman of the Committee for Hotels for the 80th Annual Session.

* * *

DUES AND ASSESSMENTS

The 1944 House of Delegates of the Michigan State Medical Society voted a $5.00 assessment for a postwar Medical Veterans' Readjustment Program which will include the employment of a postwar counselor (a Doctor of Medicine) who will consider the problems of our returning military members connected with (a) relocation; (b) postgraduate medical education; (c) finances.

The 1944 House of Delegates also voted to continue the special $10.00 per capita assessment for public education purposes which proved its value during the past twelve months. This assessment will be earmarked for the exclusive purposes of public educational programs.

These assessments will be effective January 1, 1945, payable on or before April 1, 1945 and will be in addition to the annual twelve dollar dues of the State Society.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 3, 1945, at 2:00 p.m.

Arrangements will be made so far as is possible for candidates in military service to take the Part I examination (written paper and submission of case records) at their places of duty, the written examination to be proctored by the Commanding Officer (medical) or some responsible person designated by him. Material for the written examination will be sent to the proctor several weeks in advance of the examination date. Candidates for the February 3, 1945, Part I examination, who are entering military service, or who are now in Service and may be assigned to foreign duty, may submit their case records in advance of the above date, by forwarding the records to the Office of the Board Secretary. All other candidates should present their case records to the examiner at the time and place of taking the written examination.

The Office of the Surgeon-General (U. S. Army) has issued instructions that men in Service, eligible for Board examinations, be encouraged to apply and that they may request orders to Detached Duty for the purpose of taking these examinations whenever possible.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

DETROIT'S MEDICAL SCIENCE CENTER

Wendell W. Anderson, president of the Medical Science Center of Wayne University, has been named chairman for the first cycle of the Medical Center's fund-raising campaign.

Goal of the first cycle will be approximately $10,000,000. The four buildings to be constructed in the first cycle program are the Halls of the Medical Sciences, to house the Wayne University College of Medicine, the College of Pharmacy, the School of Mortuary Science, and allied programs; a university hospital for teaching and research; a classroom, administration and dormitory building for the recently authorized College of Nursing; and a powerhouse, laundry and service building.

Eventual goal of the Medical Science Center campaign is $50,000,000, of which approximately $20,000,000 will be for construction and equipment of buildings, and $30,000,000 for the endowment of program and research.

The City Plan Commission has approved a 53-acre, fifteen-block site for the Medical Science Center situated east of the Art Center. The Corporation Counsel has begun the condemnation of the first three blocks of this site.

War Medicine

MEDICAL SUPPLY ITEMS

The volume of items processed by the Medical Department exceeded that of the Quartermaster in September of this year. The Medical Department processed 144,000 line items for overseas as compared to Quartermaster's 141,000. Only Ordnance and Engineers exceeded the Medical Department. A like comparison is evident for domestic shipments. The Medical Department processed 313,000 domestic line items and was only exceeded by Ordnance and the Quartermaster.

STRENGTH OF THE ARMY MEDICAL DEPARTMENT

In connection with the recent announcement that the Army is no longer recruiting physicians, the following figures are of interest:

The Army Medical Department has grown from 8,010 at the beginning of World War II until it now numbers 680,891. Of this number approximately 44,651 are in the Medical Corps, 14,948 in the Dental Corps, 2,012 in the Veterinary Corps, 2,364 in the Sanitary Corps, 15,078 in the Medical Administrative Corps, 59 in the Pharmacy Corps, 40,305 in the Army Nurse Corps, and there are 559,327 enlisted men, 813 Physical Therapy Aides, and 1,334 Hospital Dietitians.

GENERAL LULL DEDICATES VAUGHAN HOSPITAL

At special ceremonies held in Hines, Illinois, Major General George F. Lull, USA, Deputy Surgeon General, dedicated Vaughan General Hospital, which will specialize in medicine and psychiatry.

Colonel Victor Clarence Vaughan, in whose memory the hospital has been named, was one of the leading bacteriologists and toxicologists of his day. He was commissioned a Major in the U. S. Army during the Spanish-American War and was a member of the commission headed by Walter Reed to study the cause and prevention of typhoid fever, then epidemic in military camps.

During the World War, Colonel Vaughan served in the Office of The Surgeon General and was on the executive committee of the general medical board of the Council of National Defense. He served as president of the American Medical Association and of the American Tuberculosis Association. He was awarded the Distinguished Service Medal for his outstanding work in epidemiology and was made a knight of the Legion of Honor by the French government. He died in 1929.

Victor C. Vaughan was formerly Dean of the Department of Medicine, University of Michigan.

WHOLE BLOOD SHIPMENTS START IN PACIFIC

Whole blood shipments to the Pacific battlefront started on November 16. The blood is collected in San Francisco, Oakland and Los Angeles by the Red Cross, typed by Army and Navy laboratories, and flown by Navy plane across the Pacific for joint use by the armed forces.

Although West Coast shipments of ice-packed whole blood started on a small scale, over 200 pints a day are now being called for to make the 3-day Pacific flight. Meanwhile, daily flights of whole blood donated in New York, Boston and Washington, cross the Atlantic within 24 hours for use in the European theater of operations.

RESULTS OF ARMY RECONDITIONING

In a little over a year of operation reconditioning has been developed to a stage where twelve thousand patients a week are being discharged to duty from the Army hospitals in the continental United States.

This statement, made by Colonel Augustus Thorndike, MC, Director of the Reconditioning Consultants Division, gave added point to his talk on the Army's reconditioning program before The Military Surgeons.

In summing up its results Colonel Thorndike said that the reconditioning program as now operating in Army hospitals has accomplished its mission of reducing the hospital readmission rate and the average period of hospitalization; has returned better conditioned soldiers to duty; and is returning disabled veterans to civilian life better fitted physically and mentally and better prepared to resume an independent, self-supporting existence.

In short, Colonel Thorndike said, reconditioning helps patients to help themselves!

* * *

ARMY MALARIA CONTROL THREEFOLD PROBLEM SAYS GENERAL SIMMONS

The Army has made great progress in the control of its No. 1 disease hazard, malaria, according to Brigadier General James S. Simmons, USA, Chief of the Preventive Medicine Service. The problem has two aspects—control in base areas and protection of troops in combat. The first is primarily mosquito control, and specially trained personnel are required to produce effective results. The malaria control organization in the Army Medical Department includes medical officers trained in malariology, and small survey and control units headed by parasitologists, entomologists and sanitary engineers.

The second aspect—protection of troops in forward and combat areas—depends upon individual measures of protection in addition to mosquito control, according to General Simmons, and strict malaria discipline must be established and enforced. Soldiers must be drilled in the use of repellents, sleeping nets, protective clothing and insecticide sprays in the same way they are trained to use combat weapons.

Concerning the third aspect—the possible spread of

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ARMY MALARIA CONTROL

(Continued from Page 18)

malaria in this country by returning soldiers—General Simmons said that members of the armed forces who have had malaria will be given sufficient treatment to render them free from demonstrable parasites before they are discharged. In addition, men who have had malaria or served in malarial regions are advised to seek prompt medical attention and have a blood smear for malarial parasites in case of illness with fever.

However, prevention of malaria in this country, as elsewhere, depends essentially upon the control of the malaria-carrying mosquito.

VIRUS TYPE EQUINE ENCEPHALOMYELITIS

All three types of equine encephalomyelitis viruses known to be present in the Western Hemisphere are capable of producing fatal encephalitis in man, according to Colonel Raymond Randall, VC, of the Army Veterinary School at Washington, D. C. In a paper presented at the annual meeting of the Association of Military Surgeons, Colonel Randall pointed out that the relatively high mortality rate of the human disease emphasizes the importance of this horse disease from the public health standpoint.

In 1941 more than 3,000 human cases were reported in the United States and Canada. Most of them occurred in North Dakota, South Dakota, Nebraska and Canada. North Dakota having the highest incidence with 1,080 cases and 96 deaths. Cases were also reported from California and Washington. The mortality rate among the human cases varied in different areas from 8 to 20 per cent, adult male farm workers having the highest incidence. This is in contrast with the Eastern type infection which in the outbreaks thus far recorded was predominantly a disease of children and had a mortality rate of approximately 75 per cent. In many instances during the midwestern epidemic of 1941 the Western type encephalomyelitis virus was isolated and it appears that the St. Louis encephalitis virus played a very minor role in the outbreak.

The evidence is ample that equine encephalomyelitis is transmitted by insects, particularly mosquitoes, and its control involves anti-mosquito measures. Horses and mules may be protected against the disease by the annual administration of chick tissue vaccines. A vaccine suitable for human use has been developed in the Army Veterinary School, Colonel Randall said, and can be made available if indications for its use should develop.

PAY ALLOWANCES FOR WOMEN MEDICAL OFFICERS

Legislation under which women officers of the Army Medical Corps will be entitled to receive the same pay allowances for their dependents as are paid to all other commissioned personnel of the Army became effective on October 1.

An act authorizing the commissioning of women physicians in the Medical Corps was approved in April, 1943, and provided that they should "receive the same pay and allowances and be entitled to the same rights, privileges and benefits as members of the Officers Reserve Corps of the Army." The Comptroller General subsequently ruled that they were not entitled to allowances for dependents.

The new law, designed to meet the Comptroller General's objections, is not retroactive to the date of women officers' commissions. The dependents for whom allowances may be paid are "husband, a child or children, or a parent or parents in fact dependent" upon the officer "for their chief support."

Approximately 75 women have been commissioned to date in the Medical Corps.

CRITICAL NEED FOR ARMY NURSES CONTINUES

Out of 27,000 recruiting letters sent by the Army Nurse Corps to nurses classified as 1-A for military service by the War Manpower Commission, only 710 replies have been received, and less than a third of these are from nurses qualified for commissions.

While the drive to recruit Army nurses lags, the number of patients being evacuated from overseas to the United States has been increased almost 300 per cent. In addition the overseas requirements for nurses continues to grow, with the quota for the month of December alone set at approximately 1,000 nurses.

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125 MICHIGAN DOCTORS NEEDED BY THE NAVY

The Army recently announced a cessation of their procurement of physicians. On the same day, the Navy emphasized its serious need for 3000 additional medical officers. Michigan's share is approximately 125. This 3000 will not fill the authorized quota desired by the Navy but will take care of its emergency needs. Any Michigan doctor interested in obtaining a commission in the Medical Corps of the United States Navy, who may secure clearance from the Procurement and Assignment Service, is urged to contact the Office of Naval Officer Procurement, 1249 Washington Boulevard, 9th Floor, Book Building, Detroit 26, Michigan.

Commander D. F. Hoyt, (MC), USNR
Senior Medical Officer.

* * *

NEW HOSPITAL CAR

On November 13, the first of a new type hospital car for use in the United States was opened for inspection in Washington, D. C.

These new unit-type cars are not converted pullmans, but are designed and built as hospital cars. They are ten feet longer, are air-conditioned, accommodate 38 patients and attendant personnel. Each includes two rows of triple-tiered beds, two compartments with three beds each, a stainless steel kitchen equipped with refrigeration, ice cream cabinet and coal range; a receiving room with four-foot side doors for loading and

(Continued on Page 22)

NEW HOSPITAL CAR

(Continued from Page 20)

unloading litter patients; two roomettes, each with toilet and shower, for the medical staff or seriously ill patients; and a baggage compartment. The car also carries a modern pharmacy unit and sterilizing equipment and in case of emergency either the receiving room or one of the roomettes can be converted quickly into an operating room.

The Glenon-type, steel-frame beds are adjustable and unoccupied center bunks can be dropped to provide seating accommodations for ambulatory patients.

Six more of these cars were to be put into operation in November, 18 in December and 75 during January, February and March of 1945—bringing the total to 100, in addition to the 120 converted hospital cars now in use.

MEDICAL RECORD OF DISCHARGED VETERANS

"When discharged veterans come to a civilian practitioner for medical advice or treatment, how may he obtain a health and medical history of the person while he was in military service?" asked a physician in civilian practice recently.

The War Department has issued a regulation which authorizes the Commanding Officer of any hospital, where a member of the armed forces may have received treatment, to release information from his or her medical records to "registered civilian physicians, on request of the individual or his legal representative, when required in connection with the treatment of the member or former member of the armed forces" (Regulation No. 40—590).

The information given must be treated as confidential.

The Navy Department and the Veterans' Administration undoubtedly will co-operate in the same manner.

* * *

ARMY LIFE-SAVING

Something vital not apparent in the periodic casualty lists of this war is the remarkably high percentage of wounded who recover and the large number who get back into action. The record is such that Surgeon Gen. Norman T. Kirk describes the work of American Army surgeons as "unparalleled in the history of warfare and is little short of miraculous."

He told the Scientific Assembly of the District of Columbia Medical Society Friday that "the survival rate among our wounded at the present time is higher than it ever has been in any army in any war at any time."

Public attention has been attracted to the spectacular accomplishments of penicillin, the availability of which, Gen. Kirk said, has permitted "surgical procedures that would otherwise not be possible. Deaths in a recent series of cases of gas gangrene treated with the drug were one-third of the average among gas gangrene victims in the first World War.

But the record is not confined to the merits of new drugs, remarkable though they are. Development of treatment of surgical technique has had much to do with the low rate of permanent disability and the speeding of recovery.

There is also the unexcelled skill of the medical men in our armed forces which, when confronted with this great emergency, was able to draw upon a profession which had progressed notably in our cherished way of life. It is something well to remember as what amounts to socialization of medicine is advocated.

The system which some theorists would undermine is paying priceless dividends in American lives.—Editorial in the *Flint Journal,* October 6, 1944.

Army casualties through November 22, 1944, were 474,898, an increase of 13,840 since the report which covered the period to November 15. Navy casualties total 77,120, an increase of 1,228 since last week. The Army figures are: killed, 91,625; wounded, 258,099; missing, 58,926; prisoners, 56,248. Navy: killed, 29,738; wounded, 33,469; missing, 9,427; prisoners, 4,486.

Approximately 11,000 seriously wounded men in need of special treatment have been flown back to the United States in fast ambulance planes since D-Day—more than 4,000 in the first month.

These giant flying hospitals, bigger than pre-war air liners, span the Atlantic in twenty-four to thirty hours. Each carries fifteen to twenty-five casualties, depending on the nature of their wounds. Over-all losses have been less than 2 per cent since D-Day.

Table of Contents

Preoperative Calm

ALTHOUGH many of the derivatives of barbituric acid have a generic resemblance in their principal action, there are significant differences which establish certain compounds in special clinical fields. For example, 'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly), while frequently prescribed for insomnia, has been found particularly useful as a preanesthetic hypnotic. Given preoperatively it serves to allay fear and apprehension, improves the patient's mental attitude, thus facilitating surgical procedure. 'Sodium Amytal' is also widely employed in obstetrics. In recommended dosage it is capable of producing amnesia without prolonging dilatation of the cervix or interfering with the strength or frequency of uterine contractions.

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The Pre-anesthetic Preparation of the Surgical Patient

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Anesthesia should be considered as the summation of the effects of premedication and the anesthetic agent proper. The selection of drugs for pre-anesthetic preparation, the amounts used and the time of administration are common sources for errors in the technique of anesthesia.

Pre-anesthetic medication has developed in a wide range from "an aspirin tablet" to "basal narcosis." A wide variety of drugs is in popular use. The rational of such therapy, the results desired and the consequences of its improper application to clinical surgery are discussed.

■ THE increasing pace at which new knowledge is being utilized to improve and extend surgical practices has provided anesthesiology with a challenge and at the same time an injunction to keep its practices in stride. The anesthetist's response, aided and abetted in no small measure by his confreres in the basic sciences and other clinical specialties, has been one of rapid improvement. For the most part, this has manifested itself in the acquisition of new drugs, improved appliances and entirely new procedures. The emphasis has been on the tools of the specialty and the efficiency of those handling the tools. The results in this direction have been encouraging. Much has been done to provide safer anesthesia for the patient. Now, and the time is opportune because the need is obvious, emphasis is being given to making the patient safe for anesthesia. In this endeavor attention is focused upon pre-anesthetic preparation. Pre-anesthetic preparation rather than pre-anesthetic medication because as the latter term is used usually, it refers to a drug given at a short interval before anesthesia is induced. Anesthesia should be considered as the summation of the effects of premedication and the anesthetic agent proper. But it is not enough to restrict the anesthetist's preparation of his patient to the premedication part of the procedure.

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Read before the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-ninth Annual Session of the Michigan State Medical Society, at Grand Rapids, Michigan, September 28, 1944.

Pre-anesthetic Medication

It is is no new practice to give drugs shortly before anesthesia is induced. Some twenty years after ether was demonstrated, Green recommended morphine injections during and immediately before inhalation anesthesia. Sixty-three years have passed since Crombi reported from India his experiences with premedication. At the turn of the century Korff was extolling "twilight sleep" before anesthesia, and twenty-five years ago Bordet was beginning the use of derivatives of barbituric acid.[1] The modern concept, however, except as related to surgical preparation, has gained little significance. This tardy recognition has been the result of the empirical use of pre-anesthetic drugs and the convenience of routinizing practices. The time-honored "quarter and one hundred fiftieth" has become so firmly intrenched that it is almost traditional

in many clinics. The slightest reflection makes it obvious that the aforesaid dose of morphine and atropine to every adult who will be anesthetized is about as scientific as an ounce of castor oil for every one who is constipated. It is convenient to routinize hospital procedures and this is true especially if they are used more or less empirically. However, once a routine is established the incentive for improvement is suppressed. Although it is unwise to advocate hasty adoption of novel proposals or quick acceptance of the new, since both are equally as dangerous as rigid adherence to older methods, any anesthetic procedure that is routinized for an operation is potentially dangerous. It is not only the operation but the patient also that must be considered. Anesthetists should follow the lead of the modern surgeon who studies the patient with a disorder requiring surgical intervention rather than a surgical disease to be eradicated.

Errors in anesthesia, and there are many; unsatisfactory administrations, and these are not uncommon, result most often from faulty preparation. The knowledge, experience and judgment needed to complete the premedication in the total regime is not exceeeded by that required to manipulate the procedure in the surgical amphitheatre. It does not suffice to excuse an unsatisfactory induction or maintenance of anesthesia for an improperly prepared patient by having a friendly surgeon say, "the patient took a poor anesthetic." The patient takes anesthesia in the manner in which it is given, poorly if given so, and poorly most often if he is improperly prepared for it. Nor is it permissible to jeopardize the patient by failing to protect against complications that may be anticipated or by increasing the hazards of complications already active by improper preparation.

The Purposes

Pre-anesthetic medication has for its primary purpose an increased margin of safety for the patient. His comfort and rapid convalescence are other important aims. The convenience of the surgeon and anesthetist are minor considerations. In the matter of safety it is pointed out usually that all anesthetic agents with the exception of nitrous oxide are protoplasmic poisons. In whatever way one may reduce the amount of these poisons needed, whether given by inhalation, by vein or by other methods, the patient's safety will be increased. It is established that patients who have received sedative drugs will require correspondingly less anesthetic agent depending upon the degree of narcosis already present. It does not follow, however, that the same dose of any hypnotic will produce the same degree of sedation in any two individuals of similar age and weight. This is not due to any great extent to an individual variation in drug effect but to the physical and emotional conditions of surgical patients.

The Rational

The thesis of Guedel is familiar wherein he correlates the reflex irritability or what might be termed resistance to anesthesia directly with oxygen demand or metabolic activity and indirectly with the state of mental activity.[6] The oxygen requirements are increased in young people, those with fever and those with an increased metabolic rate from any cause. Such emotional disturbances as those associated with pain or fear add to the metabolic activity, and if suppressed, patients will require smaller amounts of anesthetic drugs to reach and maintain surgical anesthesia. Add to these the evaluation of the physical fitness of the individual, for example, contrasting the vigorous outdoor type with those of lassitude and slight muscular development, and the basis for choosing pre-anesthetic medication and the amounts needed is established.

In practice this tenet serves as a useful guide in the proper pre-anesthetic medication. To illustrate, patients with elevated metabolic rates, such as those with hyperthyroidism or infections, can be given properly a much larger amount of sedative drugs than is needed or is safe when there is a normal metabolic rate. Likewise for the old and young, a decreased amount of sedatives is imperative and can be approximated from Guedel's recommendations. However, such an evaluation of the patient is incomplete for adequate preparation with drugs. Other considerations are the anesthetic agents and techniques that will be employed later, the nature of the surgery to be completed, the postoperative requirements and of greatest importance, the nature of existing disturbed functions that may influence either the response to pre-anesthetic or anesthetic drugs. Simple illustrations are numerous. One would not argue for a vasapressor

drug before ether anesthesia because they are useful during spinal anesthesia. Nor would one presume that the same medication should be used when nitrous oxide is to follow that would be required when cyclopropane is chosen. The former agent is considerably less potent. Similarly, the different effects of the latter gas and ether are known well enough to recognize the need for variation in choosing pre-anesthetic drugs.

One could mention many operations that influence the use of sedatives. If a cranial exploration is proposed, an increase in intracranial pressure should not be produced with opiates. When shock is imminent one does not choose high spinal anesthesia.

An example of the postoperative needs is the patient with surgical diseases of the chest who should not have abdominal distention or a reduced cough reflex from hypnotics or opiates to interfere with pulmonary ventilation. Finally, disturbed physiological functions must be considered. Advanced hepatic insufficiency would contra-indicate avertin since it is conjugated in the liver with glycuronic acid. This discussion could continue with innumerable circumstances similar to those mentioned that need to be added as information in adopting the increased metabolism thesis to clinical pre-anesthetic medication. It may serve the purpose better to consider the more popular drugs in use and point out some of their limitations.

The Drugs

The opiates have a well-deserved place at the top of the list of drugs for use immediately before surgical anesthesia is induced. The morphine salts are representative and most widely employed. The profound analgesic effect of morphine is advanced to justify its use to control pre-anesthetic pain. It is readily agreed that such use is indicated but it should be remembered that there are other methods to control pain and secure comfort. Among these are nerve blocking, nursing care, freedom from worry and fear and other analgesic drugs. Their use should not be ignored in the relief of pain. Too much morphine before anesthesia may provide many difficulties for the anesthetist and many dangers for the patient. The decrease in respiratory minute volume exchange and the raised threshold for respiratory stimulation, both chemical and nervous, if severe, may be a real hazard during and immediately after anesthesia. As an example of the difficulties for the anesthetist, could be cited the circumstances where it becomes more difficult to attain surgical anesthesia with ether because of too much morphine. Shallow, slow breathing and decreased sensitivity of the respiratory center to the irritant effects of ether prolong induction. If it is pushed, laryngeal spasm frequently follows and while spasm is present ether is absorbed by tissues, anesthesia becomes lighter and the process must be started again. Such inductions are often complicated by a prolonged excitement stage and copious secretions. Also with cyclopropane which is not stimulating, too liberal use of morphine causes respiratory depression and activates the asphyxial reflex stimulation of respiration (carotid body). When anesthesia is induced with a high concentration of oxygen, the reflex is obtunded and apnea results from further depression of the respiratory center by cyclopropane. The depression of the vasomotor center with large amounts of morphine may be a factor in circulatory collapse. The depression of the temperature-regulating center may favor heat retention or exhaustion. The decreased hepatic function and hyperglycemia, the constipating effect, stimulation of the vomiting center, increased intracraninal pressure and many more side effects from morphine should be kept in mind when it is used for analgesia or premedication of the surgical patient.

Despite this disparaging discussion of morphine as representative of the opiates, it remains the most useful of all drugs for premedication. Useful, that is, if it will not be given injudiciously when its untoward effects would enhance an already disordered physiological function. Its great usefulness follows not only from its analgesic effect or that it is a cortical depressant, but from the favorable decrease in metabolic activity which reduces the requirements for complimental anesthesia. To achieve this favorable effect, not only the dose, but the time and route of administration, assume importance. The objective and subjective depression with morphine does not parallel the analgesic action. When given subcutaneously, more than an hour will elapse before subjective narcosis attains its maximum. If it is given at a shorter interval before anesthesia is induced, its value is decreased

greatly, and often the anesthetist may realize that maximum effects are reached at a time when the patient is already deeply anesthetized and with a high concentration of anesthetic agent in his tissues. A dangerous overdose may be the outcome. When given intravenously, and it is altogether likely that this will soon be the rule, the desired effects are to be had in about ten minutes.

An analgesic recently added to those useful in premedication is marketed as demerol. Its action in therapeutic doses resembles that of morphine although the structural formula of the drugs are dissimilar. It has not been evaluated conclusively, but a recent comparative study in dogs and man concludes that it provides psychic sedation, facilitates induction, has fewer side effects such as nausea and vertigo and reduces the amount of complimental anesthetic drug comparable to morphine. It does not depress respiration or other vital functions to the same degree as does morphine and it is more effective in drying secretions.[8] More recently the impression is being established that one of its more favorable indications is in the preparation of elderly individuals.

Apomorphine in sub-emetic doses (1.5 to 2.0 mgs.) almost equals morphine in narcotic action. It is useful in combating delirium and has been of value for the patient addicted to alcohol.

It is common practice to combine with injections of morphine or demerol either atropine or scopolamine. Until recently these alkaloids of the belladonna plant were used primarily to depress salivary activity. This is an essential effect but by no means the primary one. Their action on the central nervous system as well as on smooth muscle is important. They counterbalance to some extent the respiratory depression caused by opiates and cyclopropane. Waters has shown that in the proper ratio with morphine, scopolamine produces an increase in minute volume respiratory exchange as contrasted with the same dose of morphine alone. The ratio was determined to be 25:1 and in the same amounts atropine was somewhat less effective.[9] Moreover, the effects on blood pressure and pulse rate are less with scopolamine than atropine although the respiratory rate is increased more with the former. The effects on secretions are similar with both alkaloids but the subjective sense of dryness is greater with scopolamine. Burstein has found that the onset of apnea was more rapid and the duration more prolonged when atropine or scopolamine was given with morphine.[3] This is the result of paralyzing the chemo-receptors of the carotid body mechanism while the respiratory center was depressed, thereby preventing anoxemic respiratory stimulation. The well-known psychic sedation of scopolamine which is not had with atropine greatly favors its use in premedication.

The most recent consideration given atropine and scopolamine in anesthesia is occasioned by their effect in modifying reflex activity of the autonomic nervous system. Attention is being directed toward reflex circulatory disturbances more frequently than in the past. The carotid sinus mechanism with hypotension and bradycardia; the vagovagal reflexes stimulated mechanically by manipulations in the thoracic cavity with cardiac inhibition, laryngospasm and apnea; the bronchospasms with lower respiratory tract obstruction are complications which may be avoided often with adequate amounts of the belladonna alkaloids. Particularly is this true when the barbiturates or cyclopropane are used since these drugs tend to increase parasympathetic activity.[1,5] When drugs such as ether are used sympathetic activity is increased and reflexes such as the abdominal traction reflexes may be hyperactive. Such sympathetic influence is enhanced by atropine and scopolamine, a fact which must be taken into account when they are used before upper abdominal surgery.

Among the more popular group of drugs used before the induction of anesthesia are the derivatives of barbituric acid. These hypnotics have the specific action of reducing the toxic effects of the local anesthetics. This prophylactic action is of a nature to make it imperative that patients who will receive any but a very small amount of local anesthetic drug should not be denied the added safety afforded by a barbiturate. These drugs are used more often, however, for their sleep-producing qualities. It should be remembered that they are not analgesic and that therapeutic amounts usually increase the sensations of pain. As sleep provokers, they are given during the evening to "insure a good night's rest" before surgery and again shortly before anesthesia is induced to relieve apprehension. They are administered orally, by rectum and intra-

venously. Excepting when regional anesthesia is employed, they are more useful from the standpoint of the patient's comfort than his safety. Barbiturates are more difficult to use than the opiates, since there is a wide difference in the numerous derivatives available and the individual variation is more pronounced with this group of drugs than with most other therapeutic agents. The duration of action, fate in the body and toxicity must be known for each drug to use it properly. For example, in therapeutic doses barbital is long acting and eliminated by the kidneys unchanged over several days. Amytal is intermediate in duration and is partly destroyed by the liver, partly eliminated unchanged, while pentothal is ultra-short acting and totally destroyed in the liver and other tissues. An example of improper use could be cited in the practice of giving by mouth a tablet of luminal (1.5 gr.) an hour before anesthesia is induced. It is a long-acting barbiturate, slowly absorbed, of low hypnotic potency and slowly eliminated. Such a dose would have slight hypnotic effect only hours after given.

The serious toxic effects of barbiturates are those of depressed functions but these are not pronounced with therapeutic doses. However, it may follow sometimes that in the anxiety to spare the patient any uncomfortable experience with surgery, these drugs are given too freely for safety. An an illustration, the individual who may be a heavy smoker with a chronic pharyngitis and copious, tenacious secretions which collect during sleep, is given a barbiturate to insure sleep. The effects are not worn off in the morning when he is given more of the hypnotic and his cough reflex is depressed with morphine. Ordinarily he would cough and clear his respiratory tract of secretions before breakfast. Now he is anesthetized with all of them retained, the action of cilia is depressed, ventilation decreased and these secretions are aspirated to the lower respiratory tract. After operation more morphine, further depression, atelectasis and pneumonia may follow. Subsequently the complication may be listed as due to the principal anesthetic agent employed.

Paraldehyde has enjoyed the reputation of a safe hypnotic without serious toxic effects, that is rapidly eliminated by the lungs. Respirations are stimulated and human tolerance seems high. Now there are accumulated data that impose extreme caution when paraldehyde is given intravenously since alveolar damage may follow with pulmonary hemorrhage and edema.[4] When given by rectum or orally, the slower absorption reduces this threat but deaths have been reported, usually claimed to be due to idiosyncrasy, that cast suspicion on similar effects even with slow absorption.

Avertin in amylene hydrate has gained a merited popularity for use before complimental anesthesia is induced. Given in aqueous solution by rectum, it is absorbed quickly (95 per cent in twenty-five minutes) and produces two effects unlike most other depressant drugs. Intracranial pressure and intraocular tensions are reduced. Its specific use where these effects are desired is obvious when there are no serious contraindications. Objections to its use are many but more particularly are associated with liver or kidney damage since the drug interferes with normal functioning of these organs. Some anesthetic agents containing halogen may produce acute yellow atrophy. Avertin has not been excluded from this list. It is an excellent hypnotic but effective for more hours than may be advisable for certain patients. It is tolerated well by the young and poorly by the aged. The doses now employed for adults in the range of 60 to 80 mg. per kilo body weight are more satisfactory than the larger doses formerly employed.

Other Pre-anesthetic Preparations

This discussion properly should include the role of many other drugs, foods, fluids and inhalation therapy in the pre-anesthetic preparation of patients. One might also include such important prophylactic procedures as the treatment of oral sepsis. These are more often discussed in reference to surgical preparation. Some common examples are insulin for the diabetic, iodine for the thyrotoxic, blood for the anemic and fluids for the dehydrated patients. Such preparation should be considered also in the role of prophylaxis for the complications of anesthesia. That such considerations are often overlooked is obvious when a few examples are mentioned. The body requirements for salt are exacting but normally may be supplied with less than the amount in one liter of normal saline. Anesthesia greatly reduces the salt tolerance. Yet normal

saline is used without considering these facts as a medium to give water before and during anesthesia. Vitamin C is depleted rapidly in patients during and after anesthesia. Animals deficient in this vitamin recover slowly or not at all from inhalation anesthesia that has little apparent after-effects on similar animals given adequate amounts of ascorbic acid before anesthesia.[2] The scope of this article will not permit more detailed discussion of these and similar factors in pre-anesthetic preparation but the future efforts toward safer anesthesia must include their serious consideration.

The Patient's Comfort

Another significant interest in pre-anesthetic preparation is the mental and physical comfort of the patient. Anesthetists have often viewed this phase of their practice with the ultimate goal of bringing the patient to the operating room and have him return without knowledge of the event. This is one reason for the popularity of rectal instillation on the ward. This may win the patient's favor but the whole question of his comfort in relation to anesthesia cannot be dismissed so easily. There has been growing the tendency to practice modern anesthesia with the new knowledge in the basic sciences, focusing attention upon laboratory techniques and neglecting the individual. The influence of emotional factors upon physiologic processes is better understood now but the specific effects these may have in determining the morbidity and mortality from anesthesia is still speculative. Some indications are suggested by the experience of the anesthetists in the war's combat zones. Patients include those of all ages and with all diseases. They afford more range for observation than in previous wars when casualties were predominantly well-conditioned young soldiers. The influence of fear, not alone fear of the outcome of impending surgery, but fear of strange surroundings, of strange people, of the fate of relatives, of death from bombs and all the other factors that enter into surgery at the front, is not completely evaluated. It is the impression that these individuals are unable to tolerate large amounts of the opiates, that they are depressed more easily with small amounts of anesthetic drugs and that vital functions such as respiration and circulation will withstand fewer insults. This is true also of the soldier, young and physically conditioned. Similarly, fatigue reduces resistance to anesthesia and influences adversely the recovery from its effects. These circumstances are not those dealt with in times of peace or in institutions removed from combat except in isolated disasters. However, the implication is clear. Many patients fear the experience of being made unconscious, fear the effects from anesthesia more intently than the outcome of surgery. They submit to surgery for the benefits from such therapy but to them anesthesia is not a therapeutic procedure. It is a disagreeable, dangerous part of the affair. Too often patients have no idea of what the experience with anesthesia has in store for them or have only the stories of friends or accounts in the press to enlighten them. Similarly, too many have not the slightest idea who will serve as anesthetist. Excepting institutions caring for the indigent, they have a part in selecting the surgeon, and an opportunity to develop confidence in his ability and interest. The anesthetist is frequently selected by the surgeon but more often by the hospital. No statistics are available to assess the influence of such practices on morbidity or convalescence from anesthesia but it must be of some consequence. As one example, patients have developed syncope while being taken to the operating room, during spinal or regional anesthesia and at the time general anesthesia was started or as venipuncture was performed. Another is the incident early during induction, referred to often as hyperadrenalemia with sudden cardiac failure. Anesthetists with extensive experience remember it simply as the rare case that "was scared to death."

The pre-anesthetic visit of the anesthetist is an integral part of preparation. Such a visit is not made with the surgeon or internist to discuss the case or plan the procedure. That should be done elsewhere. The visit is made to become acquainted, gain confidence, learn the anesthetic history and to observe the patient in an environment other than the operating room. The surgeon can ably assist by giving the patient the assurance that anesthesia will be conducted by one with experience and skill. This is much more important than extolling the merits of a drug to be employed.

Finally, it should be pointed out that the significance of proper preparation of patients for

anesthesia is generally underemphasized. In the past, emphasis has been placed upon making anesthesia safe for the patient and too little attention given to making patients safe for anesthesia. It should be appreciated that no agent or method for anesthesia offers security for the patient not properly prepared. It must be realized that surgical patients are no longer satisfactorily grouped as clinical entities or types of diseases but that each is an individual requiring particular safeguards and preparation with the viewpoint not alone of existing pathology but of the patient as a whole. The routine use of any drugs for preparing patients for anesthesia is no longer accepted practice. Pre-anesthetic preparation must be rigidly individualized.

Summary

The role of pre-anesthetic preparation of the surgical patient is evaluated, its rationale presented and its practice outlined. The drugs in common use for pre-anesthetic medication are discussed. The anesthetist's role in such preparation is suggested.

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The Clinical Manifestations of Sulfonamide Toxicity and Hypersensitivity

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Because the literature on the sulfonamides has grown so rapidly it is difficult to keep abreast of the developments, a review of the clinical manifestations of the toxic effects is presented. These reactions to sulfonamides may be roughly classified into the following four groups: (1) The immediate toxic effects which are seen early in the course of therapy such as nausea, vomiting, headache, dizziness and diverse mental effects, as well as a direct nephrotoxic reaction with albuminuria and anuria; (2) The hypersensitivity reactions, which develop after several days of continued therapy or on the administration of a second course of the drug and are similar to serum sickness, including fever, dermatitis, conjunctivitis, arthralgias, prostration, delirium, urticaria, lymphadenopathy, bronchial asthma, jaundice and renal damage; (3) The disorders of the blood, many of which cannot be clearly classified at present either as hypersensitivity manifestations or the result of a direct toxic reaction; (4) The effect of precipitation of the drugs or acetyl forms on the urinary tract.

Special emphasis has been placed on the incidence and manifestations of the more common forms of the hypersensitivity reactions. Suggestions have been made concerning the time to look for toxic effects and the manner in which they may be avoided.

■ THOUGH sulfonamide drugs are of great therapeutic value the numerous reports of toxic effects resulting from the use of these compounds are evidence that the use of these drugs may at times be dangerous as well as life saving. The danger lies not only in the immediate toxic manifestations but also in the production of remote effects which may be even more serious. With the development of new compounds from the sulfanilamide base the immediate toxic reactions have been considerably decreased. Consequently, there is a greater tendency to regard the occasional untoward effect as of minor significance and to administer the drugs to patients in whom there may be only a remote possibility that such therapy will be helpful. Too little consideration is often given to the possibility of producing a sensitivity to the drug which may make the subsequent

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use of sulfonamide compounds dangerous or contraindicated when the patient is suffering from an infection for which sulfonamide therapy might be life saving.

Because the literature on the sulfonamides and on their toxic effects has grown so rapidly that it is difficult to keep abreast of the developments, a review of the clinical manifestations of the toxic effects is presented in this discussion. No attempt is made to describe the pathologic lesions found following the use of sulfonamides. Of particular interest in this regard, however, is the comprehensive review of the subject by Simon[39], the more recent reports of autopsies following deaths from sulfonamides[3,12,19,27,28], and the observations of Rich[45,46], on the role of hypersensitivity in periarteritis nodosa.

Incidence of Toxic Effects

It is difficult to evaluate the incidence of the toxic effects from the reports in the literature since this will vary with the type and the amount of the drug administered, with the duration of treatment, and with the repetition of treatment. Thus the number of cases exhibiting reactions after receiving sulfonamide therapy for two or three days will be considerably less than if therapy were continued for twenty or thirty days. Long[23], in a summary of the toxic effects of the commonly used sulfonamides given to several thousand patients in variable doses over variable periods in routine hospital management has found that toxic manifestations, as fever, rash, hemolytic anemia, leukopenia, agranulocytosis, hematuria, oliguria and heptatitis, occur in 11.9 per cent of the cases with sulfanilamide therapy, 15.9 per cent with sulfapyridine, 18.6 per cent with sulfathiazole, and 6.5 per cent with sulfadiazine. The experience with sulfamerazine or sulfamethazine is as yet insufficient to permit clear-cut conclusions concerning the incidence of toxicity of these drugs. The reports at the present time, however, would suggest that sulfamerazine has about the same toxicity as sulfadiazine.[1,14]

The untoward reactions common to all sulfonamide compounds for the sake of simplicity may be roughly classified into three groups: a direct toxic effect which may manifest itself shortly after the drug has been administered; a state of hypersensitization or hypertoxicity which may appear after several days of continued therapy or after the readministration of the sulfonamide; and the effects on the kidneys and urinary tract resulting from the precipitation of the drug or its acetylated form. Unfortunately, the information concerning some toxic manifestations is insufficient at present to permit such a classification. This is particularly true of the blood disorders that follow the use of the sulfonamides since some reactions might suggest a direct toxic effect while others with similar clinical characteristics would appear to be the result of a sensitivity.

Immediate or Direct Toxic Effects

The immediate toxic effects of the drug are usually quite mild but may vary in intensity and frequency with the dose and type of sulfonamide compound administered. All compounds in susceptible patients will produce nausea and vomiting presumably through a direct effect on the central nervous system. These symptoms were common with sulfanilamide and sulfapyridine but occur in only about 10 per cent of the cases treated with sulfathiazole, sulfadiazine and sulfamerazine. The other effects on the nervous system likewise are noted less commonly with the last three drugs than they were with the earlier compounds. Though headache, diziness, lack of coordination, mental lapses and psychoses were not uncommon sequelæ in sulfanilamide and sulfapyridine therapy they occur so rarely with sulfathiazole or sulfadiazine that these drugs may be given in small doses to patients pursuing their usual daily routine. At times, however, serious disturbances will occur especially when administered in large doses or to patients with pre-existing disease of the nervous system. Dysmorphopsia, aphasia, agraphia, stammering, toxic psychosis, peripheral neuritis, encephalomyelitis, myelitis, optic neuritis, transitory myopia, meningeal signs, blindness and convulsions have been described as a result of sulfonamide therapy.[21]

Some reports suggest that sulfonamides may exert a direct nephrotoxic effect as well as produce kidney lesions from the precipitation of the drug. In such cases the evidence of renal involvement occurs early in the course of therapy and consists of heavy albuminuria, aliguria, anuria, and nitrogen retention. This is associated with microscopic evidence of tubular degeneration, glomerular swelling and occasionally widespread necrosis of the renal parenchyma.[26,29]

Other untoward effects of the sulfonamides such as the disorders of the blood, hepatitis, or

the manifestations of a state of hypersensitivity to the drug may appear soon after the onset of treatment. Though in many instances they are immediate, toxic effects may not necessarily be the result of the direct effect of the drug itself and, therefore, are placed in a special group for later discussion.

Hypersensitivity Reactions

One of the most common and serious complications of sulfonamide therapy is the development of a state of hypersensitivity or hypertoxicity to the drug. These reactions are in many respects analogous to the clinical syndrome associated with serum sickness.[24] Like serum sickness the reaction is likely to develop during the second week. It may be manifest by the gradual or rapid development of many or all of the following effects: fever, chills, nausea and vomiting, skin eruption, conjunctivitis and episcleritis, muscle aches, arthralgias, profound prostration and transient delirium.[13,25] Other manifestations such as albuminuria, oliguria, anuria, edema, urticaria, lymphadenopathy, splenomegaly, jaundice, bronchial asthma and leukemoid reactions have been noted on occasions in association with this type of reaction. The drug reaction differs from serum sickness in that no antibodies to the sulfonamides have been found by the usual methods. Efforts to demonstrate a sensitivity to the drug itself by means of skin tests or passive transfer have in general been unsuccessful.

It has been demonstrated that sulfonamides, especially sulfathiazole, may combine with plasma proteins.[4] It would appear likely that in the body a combination between the serum proteins and the sulfonamides may be formed which acts as a foreign protein causing an immunological reaction similar to that associated with the injection of a foreign serum. Thus no antibodies would be formed to the drug itself but only to the combination of the serum protein and the drug. Wedum[45], was able to demonstrate sensitivity in guinea pigs given injections of sulfonamide azoprotein. Recently Leftwich[20] has described a method by which positive skin tests may be obtained in patients who have exhibited hypersensitive reactions to any of the sulfonamide drugs. The material used for skin testing consisted of serum obtained from patients who had received a sulfonamide for more than five days with a concentration of the drug in the serum greater than 2 mg. per 100 c.c. This test was found to be reliable in twenty-eight of thirty hypersensitive patients.

Since these hypersensitive reactions to the drug rarely occur before the sixth or seventh day and at times not until the third week of therapy, many patients receiving the sulfonamides for a shorter time will not experience such a reaction though sensitivity to the drug may develop. The incidence of these reactions is difficult to evaluate since it may vary with the duration and intensity of treatment and little attention has been paid to the minor manifestations such as malaise, muscle aches, conjunctivitis, etc. that develop several days after the onset of treatment. The incidence of the more dramatic episodes of a hypersensitivity reaction such as fever, chills, and dermatitis has been determined. In Long's large collection of cases, fever and dermatitis occurred with sulfanilamide therapy respectively in 5 per cent and 2.2 per cent of the cases; with sulfapyridine in 3.1 per cent and 2 per cent; with sulfathiazole in 6 per cent and 5.2 per cent, and in only 1.6 per cent and 1.3 per cent of the cases following the use of sulfadiazine.[23] It is probable that the incidence of these reactions would be considerably greater if the cases receiving large doses of the drug for seven days or longer were to be considered separately.[25]

The clinical proof of a sensitivity to sulfonamides is the development of a hypersensitivity reaction to a second course of therapy. Several factors may influence the frequency with which such effects occur. The type of drug used, the dosage, the duration of treatment, the interval between the first and second administration and the dosage on the second administration of the drug are important considerations in evaluating the frequency with which a state of sensitivity may become manifest. In some instances the sensitivity may be transient while in other cases it may persist for several years.[20] Children may be less likely to develop sulfonamide sensitivity than adults.[7]

Reports concerning the incidence of sensitivity to the sulfonamides have varied widely probably because of the large number of factors affecting the manifestation of such a sensitivity. Lyons and Balberor[25] readministered 4 grams of sulfathiazole followed by 1 gram every four hours to fifty-three older adult patients two to fourteen days

after the completion of an asymptomatic short initial course of the drug. Nineteen of these patients (36 per cent) developed a fever and other manifestations of the hypersensitive reaction in an average of $13.2 + 13.2 \pm .4$ days after the initial exposure to the drug. Rantz[34] has estimated that 25 per cent of the patients receiving sulfathiazole may develop a sensitivity. From this it would appear that the readministration of sulfathiazole shortly after the completion of an initial course of the drug is associated with a considerable increase in frequency of the hypersensitivity reactions. This has recently been confirmed by Dowling and Lepper[6] who found an increase in the incidence of drug fever on the second course of sulfathiazole, sulfadiazine and sulfapyridine. They noted reactions in 17 per cent of fifty-three cases receiving a second course of sulfathiazole and explained lower incidence of reactions from those above on the fact that half of their cases received only half doses of the drug with the second course. They noted a greater incidence of reactions when larger doses were readministered.

On the other hand quite different results have been reported in a group of fifty-five soldiers to whom sulfathiazole was readministered in variable doses. Only six of these cases developed any evidence of hypersensitivity.[11] The discrepancy in this report from the other observations may be due to the difference in dosage, the time the second course was given, and the age groups. It would appear likely that with a sufficient interval between courses sensitization to the drug may disappear in some patients. Nelson[30] is reported to have found that the readministration of sulfathiazole in routine hospital therapy was not associated with an increased incidence of reactions. It is also true that 20 to 25 per cent of the patients who have had a hypersensitive reaction to a second course may not develop a similar reaction with the administration of a third course.[23,25] Fink and Wilson[7] in a study of the incidence of these reactions in children on the readministration of sulfathiazole or sulfadiazine found that only seven of 177 cases so tested developed fever. The drug was repeated up to one and one-half years following the initial exposure and it is interesting that all of the cases having a reaction had finished the first course of the drug only one to six weeks before the development of fever with the second course.

Sulfathiazole appears to produce a greater incidence of sensitivity than the other sulfonamide compounds. This may be due to the fact that sulfathiazole is bound to the serum protein to a greater extent than other compounds.[4] Dowling and Lepper[6] noted only 7.4 per cent febrile reactions to the second administration of sulfadiazine in 68 cases and 9.1 per cent reactions to the second administration of sulfapryidine. Leftwich[20] found that 21 of the 30 hypersensitive patients he studied developed a positive skin reaction with sulfathiazole compared to four cases reacting to sulfapyridine, three to sulfadiazine, and four to sulfamerazine. Talbot and Adcock[43] in a study of the febrile reactions following a second administration of sulfadiazine found that fever developed in only three of thirty-four cases who had received the initial course without difficulty.

When a hypersensitivity reaction to a sulfonamide does occur the further readministration of the drug in the future is likely to reproduce the same reaction in about 75 per cent of the cases.[23,25] In one case a febrile reaction was reproduced two years later.[9] It is usually the rule that patients who develop a hypersensitive reaction to one compound may be able to take others without difficulty. It is not always true, however, for occasionally a state of hypersensitivity to many or all sulfonamide compounds may be produced.

Because of the frequency and severity of these reactions some of the more common manifestations of the hypersensitive state as the fever, dermatitis, changes in the central nervous system and kidney lesions will be discussed in more detail.

Fever

Drug fever, one of the more striking reactions to the sulfonamides, usually is seen during the second or third week of continued therapy if the patient has not previously been exposed to the drug. In some cases the fever is seen as early as the second day and in others not until the fifth or sixth week and occasionally it develops shortly after the discontinuation of therapy. It may start insidiously and gradually increase or come on abruptly with shaking chills and a rapid rise in temperature to 105-106 degrees. It is usually accompanied by other manifestations of the hypersensitive state particularly by profound prostra-

tion, joint and muscle pains, and at times delirium. In patients previously exposed to the sulfonamide compounds and who have developed a latent sensitivity, the readministration of large doses may precipitate an abrupt febrile response within a few hours. With cessation of sulfonamide therapy the fever subsides usually within forty-eight hours but at times some temperature elevation may persist for several days and the fever disappears by lysis.

Dermatitis

Skin rashes of many types have been noted following sulfonamide administration which, like fever, usually develop during the second or third weeks of therapy. Though skin changes are often associated with fever they may occur with other manifestations of hypersensitivity. The type of dermatitis varies considerably from patient to patient and depends to some extent on the type of sulfonamide compound used. An erythema nodosum or urticarial lesions are more commonly seen following the administration of sulfathiazole while a morbilliform or maculopapular type of reaction is more often seen with sulfadiazine.

The skin appears to be somewhat photosensitive and the eruption is more likely to appear following exposure to sunlight. In most cases the dermatitis will gradually subside when the sulfonamide therapy is stopped. The continued administration of the offending drug tends to increase the severity of the eruption and the other manifestations of the hypersensitivity reaction may then become more prominent. In some cases continued therapy has led to the development of serious and sometimes fatal exfoliative dermatitis. Readministration of the drug is likely to reproduce the skin eruption.

It is interesting that the local application of sulfathiazole ointments may be associated with sufficient absorption of the drug to produce not only a local cutaneous sensitization[2,39,46] but also a general hypersensitivity reaction to the drug when it is administered orally.[22] The cutaneous reaction may take the form of a local contact type of dermatitis with or without a disseminated eruption or it may appear as a local or generalized exacerbation of the dermatitis for which the patient is being treated.[39]

The oral administration of sulfathiazole to patients who have used sulfathiazole ointment in the past has produced not only the manifestations of a generalized hypersensitivity reaction including fever, chills, malaise, but also a dermatitis often localized to the areas previously exposed to the drug.[22] Evidence of the cutaneous sensitivity can at times be obtained by patch tests. Somewhat similar reactions have been described in a patient sensitive to procain and other local anesthetics who developed erythematous pruritic edematous reactions at every site of previous application of a local anesthetic following the administration of sulfanilamide by mouth.[11]

Nervous System

There is some evidence to suggest that the hypersensitivity reaction to sulfonamides may be associated with changes in the central nervous system. It is certainly true that delirium and a toxic psychosis frequently accompanies the febrile reaction. Little[21] has ascribed other neurological manifestations such as peripheral neuritis to the intermittent administration of the drugs. Longcope has noted one case of coma and encephalitis following a hyperstensitivity reaction.[24] Another case of encephalitis with associated renal changes proven by autopsy has been reported recently.[27]

Renal Damage

Another serious manifestation of hypersensitivity is the development of albuminuria, oliguria and, at times, anuria shortly after the readministration of a sulfonamide.[32] This may be associated with other manifestations such as fever, dermatitis or conjunctivitis. The fact that no crystals may be found in the urine even after catheterization of the ureters suggests that the suppression of urine must be in the kidney itself. The immediate cessation of sulfonamide therapy and supportive treatment may be associated with a return of kidney function as the other evidences of the hypersensitivity reaction disappears.

Differential Diagnosis

The differential diagnosis between the hypersensitivity reaction in its various forms and complications of the disease for which the patient is receiving sulfonamides may at times be difficult. In patients who have not previously received sulfonamides a sudden change in their clinical course after the sixth day of therapy should be viewed with suspicion. Usually more than one manifestation of hypersensitization may be pres-

ent or may develop in a few hours. The presence or absence of a leukocytosis may not be of aid. Though in the majority of patients these reactions are not associated with changes in the white blood cells some may show considerable change and at times a leukemoid response of the bone marrow may be present.

Blood Disorders

Blood disorders such as agranulocytosis, acute hemolytic anemia, and thrombocytopenic purpura are uncommon but exceedingly serious complications of sulfonamide therapy. Fortunately they are seen less often with sulfathiazole and sulfadiazine than with sulfapyridine or sulfanilamide therapy. It is not clear if these are the result of a hypersensitivity or if they are due to the direct toxic effect of the sulfonamides.

Acute hemolytic anemia, though rare, occurs early in the course of sulfonamide therapy and is usually seen during the third to fifth day of treatment.[15,44] It is characterized by a rapid decrease in the erythrocytes, jaundice, urobilinuria, leukocytosis, reticulocytosis and at times in severe cases hemoglobinuria and uremia. It would seem that these reactions are an expression of an individual idiosyncracy to the drug which in some cases may have been acquired through exposure to other compounds of a similar nature and in other cases may have rapidly developed during the sulfonamide therapy. This is suggested by the fact that readministration of the drug is often followed by a similar episode.

A more slowly developing anemia associated with hemolysis of erythrocytes is not infrequently seen with sulfanilamide and especially with sulfapyridine therapy but is rarely seen with the use of sulfathiazole or sulfadiazine. It is usually not an important complication of therapy since it is easily controlled by transfusions and is probably the result of a toxic effect on the bone marrow and red blood cells.

Thrombocytopenic purpura has been noted following sulfathiazole and sulfadiazine as well as with the use of the earlier sulfonamide compounds. Too few cases, however, have been studied to be certain if it is the result of a direct toxic effect on the bone marrow or a hypersensitivity reaction to the drug. In some of the cases reported the thrombocytopenia developed early in the course of sulfonamide therapy, on the second or third day, which might suggest a direct toxic effect or an idiosyncracy developed by previous exposure to related compounds. In other cases the purpura was seen after six or more days of therapy or with the readministration of the drug and it is possible that in these cases a sensitivity to the drug was developed during the course of therapy. Readministration of the drug following recovery from such a reaction may promptly precipitate another attack.[17,38] Gorham et al.[10] on the other hand, call attention to the similarity between the clinical signs of the hematotoxic action of benzol and aniline and those of the chemically related sulfonamide compounds. Kracke[31] has shown that the platelet count tends to decrease on the first day of sulfathiazole therapy with a decided increase in the number of platelets on the first day after the drug was discontinued. This might suggest that the sulfonamides exert a primary toxic effect on the platelets.

In contrast to acute hemolytic anemia and thrombocytopenia, it is uncommon to see the development of leukopenia or agranulocytosis resulting from the administration of sulfonamides early in the course of therapy unless the patient has previously been exposed to sulfonamides. The decrease in the white blood cells is not usually encountered before the end of the second week and is more frequently seen between the fifteenth and twenty-fifth days of therapy. This reaction is seen especially with the use of sulfapyridine but is occasionally a complication of sulfathiazole and sulfadiazine therapy.[16] In some cases it appears to be the result of a hypersensitivity reaction since readministration of small amounts of the drug will produce a rapid fall in the white count and granulocytes. In other cases, however, readministration is not attended by changes in the blood picture.[23] This is a particularly important point since it has been generally assumed that the agranulocytosis associated with sulfonamide therapy was the result of an idiosyncracy. Since sulfonamides would be especially important in controlling the serious secondary infection associated with agranulocytosis, it is possible that they should be continued in spite of the agranulocytosis. Three cases of agranulocytosis that developed after sulfadiazine recovered completely with the prompt readministration of the drug and spontaneous regeneration of the granulocytes occurred during sulfadiazine therapy.[31]

Another type of leukopenia and agranulocy-

tosis has been described in rats and may have its clinical counterpart in man receiving sulfonamides over a considerable period of time. It was found that the administration of succinylsulfathiazole or sulfaguanidine to rats fed a purified diet produced a leukopenia and agranulocytosis which would respond to the administration of liver or liver extract.[5,41] It is suggested that the sulfonamide compounds may produce this picture through a lowering of the intestinal synthesis of essential growth factors. It is possible that some of the cases of agranulocytosis noted in man following prolonged administration of sulfonamides may be the result of a disturbance in folic acid metabolism and the subsequent failure of maturation of white blood cells rather than a direct toxic effect or sensitivity effect. Under such conditions the favorable response to liver extract might be anticipated.

Liver Damage

Though sulfanilamide and to a lesser extent sulfapyridine have produced serious liver damage it is uncommon with the use of sulfathiazole and sulfadiazine. There is considerable evidence that sulfanilamide may exert a direct toxic effect on the liver early in the course of therapy. On the other hand, there are some cases in whom hepatitis developed in association with other manifestations of the hypersensitivity reaction. The problem has been well reviewed recently by Peterson et al.[33] in support of their belief that the presence of liver damage or jaundice does not contraindicate the use of sulfadiazine and its use may be indicated in cases of acute hepatitis associated with bacterial infections.

Urinary Precipitation

A common and usually avoidable complication of sulfonamide therapy is the precipitation of the compounds or their acetyl forms in the kidney tubules or ureters in sufficient amounts to produce mechanical obstruction to the flow of urine. Since these drugs and their acetyl forms are weak acids that are relatively insoluble in water or the normally acid urine, precipitation is likely to occur as the alkaline ions and water are reabsorbed from the glomerular filtrate in the tubules of the kidney producing a relatively high concentration of the drug in an acid environment. The amount of precipitation and the complications resulting from it varies considerably with each of the compounds now in use depending upon the differences in the solubility of the free and acetyl forms and upon the rate of excretion of the drug. Sulfanilamide, the most soluble of all the compounds, is rarely associated with clinically significant precipitation. Sulfathiazole which is excreted very rapidly has only a small proportion of acetyl sulfathiazole in the urine but because of the rapid rate of excretion high concentrations of the drug occur in the urine with subsequent precipitation. On the other hand sulfapyridine and sulfadiazine are excreted more slowly and consequently have a greater proportion of the drug in the more insoluble acetyl form which favors greater precipitation. It is because of this that other compounds such as sulfamerazine or sulfamethazine have been developed which are slowly excreted and have an acetyl form that is more soluble.

It is not uncommon to find crystalluria in patients receiving sulfonamides. This is of little significance in most cases since crystals are likely to form as the urine cools from body temperature. On the other hand crystalluria in a warm freshly voided specimen is evidence that precipitation is occurring in the urinary tract although symptoms may not be produced. At times renal or ureteral pain, hematuria, burning on urination, or oliguria are the first indication of significant precipitation of crystals. This may go on to anuria with renal retention not only of nitrogenous products but also of the sulfonamides thereby causing acetylation to become more marked and thus predisposing to further precipitation and to the complete suppression of urine.

Fortunately these complications can usually be avoided. This is due to the fact that the solubility of these drugs and their acetyl forms may be greatly enhanced in an alkaline medium through formation of the soluble sodium salts. Thus a change in the pH of the urine from 6.5 to 7.5 may increase the solubility of sulfadiazine ten times.[8] The solubility of free or acetyl sulfathiazole and sulfadiazine greatly increases as the pH of the solution is raised above seven so that it is of great importance to maintain an alkaline urine while these drugs are being administered. The maintenance of a large urine volume may also aid in the removal of the compounds without precipitation but is a relatively small factor in comparison to the alkalinization of the urine.

Avoidance of Toxic Effects

Though the incidence of untoward complications with the sulfonamides is not high, especially with the use of sulfadiazine, deaths directly attributable to the drugs do occur. Sutliff, et al.[42] estimated that in New York City there was one death in every 1,610 cases of pneumonia treated resulted from complications of sulfonamide therapy. Long[23] as estimated that 5,000 deaths per year result from the use of sulfonamides.

Fortunately, many deaths and severe sulfonamide reactions may be prevented by intelligent use of these drugs. Careful considerations must be given to the reasons for instituting sulfonamide therapy in a particular case and the drugs should be avoided in cases where there is only a remote possibility that such therapy might have a beneficial effect. Care should be taken to determine as far as possible the patient's previous experience with the drugs and the type of compounds previously administered.

Adequate supervision of the patient receiving the drugs will often prevent serious complications. This does not necessarily imply extensive laboratory procedures but does involve careful clinical observation and occasional laboratory tests. During the first few days the patient should be observed for toxic effects on the central nervous system. In patients who have received a course of sulfonamides in the past it is especially important to be alert during the first few hours of the readministration of the drug for the possibility of a hypersensitivity reaction, especially when large doses are administered. Early in the course of treatment the rare complications of an acute hemolytic anemia or thrombocytopenic purpura might be anticipated. The urine should be examined to reveal evidence of a direct nephrotoxic action of the drug and also to evaluate the presence of crystalluria.

Between the second and third weeks of therapy the hypersensitivity reaction is most likely to develop as well as the serious complication of agranulocytosis. White blood cell counts at this time are particularly indicated. Careful clinical observation of the patient may abort a hypersensitivity reaction before it becomes serious. The sudden development of malaise, arthralgias, conjunctivitis, skin rashes, or fever without other apparent cause should suggest such a reaction and immediate cessation of therapy may abort the attack. Beyond the third week of therapy the possibility of the development of an agranulocytosis must always be kept in mind. At all times during sulfonamide therapy it should be remembered that the drug is being removed by the kidneys and that in an acid urine it is relatively insoluble so that crystals are apt to form. Since the solubility of the drug in its free or acetyl form is greatly enhanced by an alkaline urine the simultaneous administration of sodium or potassium bicarbonate is beneficial. The common practice of administering sodium bicarbonate in equal amounts with the sulfonamide will not necessarily insure an alkaline urine and it is often necessary to administer larger amounts of alkali. Frequent examinations of the urine to be certain it has an alkaline reaction, as well as a careful maintenance of an adequate urinary output, will be helpful in preventing mechanical obstruction of the urinary tract.

Summary

Some of the more common, toxic effects resulting from the use of sulfonamides have been discussed with particular reference to the time they are most likely to occur. The role of these drugs in producing a state of hypersensitivity analogous to a foreign protein reaction has been discussed. More careful clinical supervision of the patients receiving sulfonamides bearing in mind the possibilities of a toxic reaction may prevent unnecessarily severe or fatal complications.

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Advance in the Prevention and Treatment of Poliomyelitis

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Newly-acquired knowledge regarding the dissemination of the virus of poliomyelitis suggests no effective method for preventing its spread and makes our traditional public health procedures appear even more futile.

No inoculum has been invented which effectively increases resistance to the virus, although encouraging animal experiments have been carried out.

During the past few years discussions of treatment have been dominated by the Kenny physiotherapy technique. This method has been widely but uncritically accepted without even quantitative clinical observations, to say nothing of controlled clinical researches, having been carried out. It is unfortunate, particularly in dealing with poliomyelitis, that physicians and institutions could not have withstood the pressure for publicity until proper studies were made. Time-supported opinion seems progressively pessimistic regarding the results of the Kenny technique.

The theory behind the Kenny technique, developed apparently in retrospect after almost fetish-like details had been established, although physiologically and pathologically naïve has, however, stimulated many researches which will prove of great value.

■ I HAVE chosen to twist the title assigned to me to allow me to confine my discussion of this most interesting and complex disease to a consideration of the therapy of poliomyelitis in the light of the advances in our theoretical knowledge of the disease in the last few years. No research on my part justifies my assuming to address you on this subject, and I can only claim a great and constant interest as a close clinical observer of the disease.

I will start with a summary which may seem most pessimistic and depressing and quite lacking in matter for headlines. Although a great deal that is new has recently been learned which sooner or later will inevitably lead to our ability to control this dreaded disease, it seems to me that at present what we know makes us have less confidence in ourselves and feel less sure of being able to do anything to control the spread of

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the disease or influence its course than we felt five or ten years ago. During the last two decades, we have subjected our patients to a long series of therapeutic experiments ending in the Kenny treatment; therapeutic trials which have often caused pain and distress and always false hopes and great expense. All have been futile or nearly so except for adding to our experience. Many of the experiments should have seemed to us ill-advised at the time; all look so in retrospect. We have been driven by uncritical public opinion, urged to do almost anything to appease a frightened public. I do not think the medical profession can look back with much pride on these experiences unless it is pride in constant and versatile, though often uncritical effort. Nevertheless, we have gained a much more exact insight into the habits of the poliomyelitis virus and the pathogenesis of the disease it causes, an insight which should enable us to avoid more wisely in the future useless therapeutic gestures and which ultimately may lead us to the control of the disease.

I would like to review the subject therefore with a discussion of pathology, pathogenesis, immunology all mixed up with our efforts at treatment; to review past errors as a guide against present and future ones.

The first good observation of the pathology of poliomyelitis is I believe still the most important and needs re-emphasis at this time.

Some seventy years ago, at a time when little knowledge of the acute phase of poliomyelitis existed, Charcot observed the cords of victims of poliomyelitis who died months and years after the paralysis had occurred. He saw withered, shrunken cords which on histological section showed no other changes but a great reduction in the number of anterior horn cells in certain parts of the cord. Some years ago, we had the opportunity to examine the spinal cords of patients who died after living some months in a Drinker respirator with such severe and widespread paralysis that before the invention of that machine they would not have survived the acute phase of the disease. We saw such extensive destruction of the great motor cells that actual cavitation in the cord appeared, so that one could pass a probe up and down a tube-like cavity in the anterior horns.

Recently in the various attempts to rationalize the so-called Kenny treatment, belief has been expressed that there is no true paralysis in poliomyelitis but that the resulting weakness was as I would express it a "pseudo-paralysis," due to some mental inhibitions or "alienation" derived from opposing tender muscles. I should like to emphasize the fact that the only pathological change that we know of that is permanent and that does not disappear after recovery from the acute stage of the disease is a loss of those anterior horn cells and we should tie to this and not be misled by physiological sophistries.

With better knowledge of the disease, the acute febrile illness that preceded or was associated with the paralysis was recognized and autopsies were done on patients dying during this stage. Many years ago, this acute pathology was beautifully described by Rissler of Sweden in a way that has not been improved upon. To summarize it very briefly, the picture in the acute stage consists of:

1. Changes in the great motor cells of the anterior horns showing different stages of a disease process varying from apparent partial degeneration to complete destruction.

2. Much more striking and extensive changes in the interstitial tissues of the cord and in the meninges. Throughout the cord, in the medulla, and sometimes in the brain itself there was evidence of acute inflammation with engorgement of blood vessels and collections of small round leukocytes in great concentration surrounding the engorged capillary vessels like dark collars. There were also less marked abnormal changes in nerve cells in the posterior horns, as well as in the brain.

For many years this inflammation and perivascular collection of white cells has been a subject of great controversy and has been the stimulus of many therapeutic ventures. Were the changes in the anterior horn motor cells primary and the other changes secondary and incidental, or was the disease in the anterior horn cells secondary to the acute interstitial inflammation? In attempts to analyze the progress of the disease, it was postulated by many that the anterior horn cells were destroyed by a local anoxemia brought about by choking off of their blood supply by the congested perivascular collection of white cells.

You probably all remember some of the attempts at therapy based on this hypothesis. Hypertonic solutions were given intravenously to

reduce the inflammatory edema of the cord and of the medulla. At the other extreme, hypotonic solutions were given combined with long continued spinal drainage. It was believed that these large dosages of parenteral water would increase the flow of spinal fluid and would actually wash away into the spinal fluid the lymphocytes that seemed to be obstructing the circulation in the capillaries. Adrenalin was injected into the cord and other efforts were made, all of which were supported not only by this theory but by reported excellent clinical results. Several methods seemed to different observers to work and were advocated with enthusiasm by their sponsors though we know now that the final results were not much different by one treatment than another and that no one offered in support of his arguments a control series of patients diagnosed the same way and as carefully observed but without the treatment.

There is now much evidence to convince us that the primary pathology is in the motor cells of the anterior horns and that all the other changes are secondary. Some very beautiful experimental work in monkeys has been carried out which I cannot take time to review in detail but which demonstrated that the virus first damaged the anterior horn cells and that the interstitial changes were secondary and did not occur in spite of inoculation with potent virus in sections of the brain or the cord where the large motor cells had been destroyed previously. All this makes us feel quite surely that these many attempts to increase the blood supply to the great motor cells were based upon a misconception of the pathogenesis and were quite futile.

Study of the pathology of the disease shows some few changes outside the central nervous system. There is definite evidence of disease in the lymphatic system, particularly manifest by engorgement in the Peyer's patches of the gut. These abnormalities, plus the evidence of meningeal inflammation, have seemed to some observers to indicate that the virus was first systemically distributed in the body and got to the central nervous system some way or other through the blood, lymphatic or spinal fluid channels. This seemed a very important conception and combined with observations regarding circulating blood immune bodies was the basis for other therapeutic experiments. It was long ago observed that the blood of men and monkeys convalescent from the disease contained antibodies. These antibodies can be demonstrated in one way only. When the serum of the convalescent animal is mixed with the virus (i. e., an emulsion of the cord of a victim of the disease) and this mixture incubated for a short time and then injected directly into a monkey's brain, the monkey remains well, while a control monkey injected with the same amount of the virus but without previous mixture with convalescent serum becomes ill with poliomyelitis. This experiment was repeated scores of times by many workers and established without a question the presence of some sort of circulating antibodies; with the demonstration of circulatory antibodies and with the assumption that the virus got to the central nervous system by way of the blood, lymphocytes and spinal fluid, it seemed logical that if convalescent serum containing these antibodies could be injected into the blood and spinal fluid of the victim early enough in the course of the disease it might block the progress of the virus to the central nervous system or prevent it from causing damage. Accordingly, in very extensive clinical experiments, many thousands of patients were given human convalescent serum intravenously and intraspinally in various dosages as soon as the disease could be diagnosed and before paralysis occurred.

A few years ago, in talking about this subject here on a platform with Miss Kenny as another speaker, I spent some time repeating the old story of this experiment with convalescent serum in an attempt to outline the possible error in other clinical experiments in human poliomyelitis. I must mention it again briefly, even though it is old history now, because this attempt to use convalescent serum seems to me almost a classic experiment in its perfect demonstration of a treacherous and common error in clinical experimentation; an error once again made in the evaluation of the Kenny treatment. In the first reports of the use of convalescent serums the results appeared excellent and the administration of this serum was enthusiastically carried out in spite of the tremendous labor involved. The patients given convalescent serum were painstakingly examined and the degree of their paralysis at different stages of their disease accurately recorded. Some hundred muscle groups in each patient were examined, and the degree of weakness quantitatively recorded so that a single fig-

ure could represent the total paralysis on a comparable basis for each of a large number of patients. The patients given convalescent serum showed far less paralysis than the control group with which they were compared, and the procedure was enthusiastically carried out for awhile without much question. It took several years, some thousands of patients, and very courageous and critical minds to detect the error in the experiment even though now it appears so obvious.

The patients given the serum were diagnosed in the pre-paralytic stage because of the concern of their families and the clinical acumen of their physicians, and were then treated. The control group not receiving serum with which they were compared were those not detected until after paralysis occurred when they were brought to a physician's attention because of their paralysis. Obviously the control group, therefore, did not include any of the patients with a non-paralytic form of the disease who also received no treatment because they escaped detection. When the experiment was repeated with serum given to only alternate patients discovered in the pre-paralytic stage by the same criteria, the comparable groups of these parallel series showed no important differences in paralysis.

Although the use of convalescent serum to produce a quick passive immunity has been discarded by clinicians very grudgingly, mostly for want of a substitute therapy, there exists therefore no good clinical evidence to justify it. Even the theoretical basis we now know was faulty because nobody can protect monkeys from poliomyelitis if the convalescent serum is not mixed with the virus before inoculation but is administered the way it must be given human patients.

The attempts to produce a temporary passive immunity having failed, an effort was made to produce active immunity by the injection of vaccines. Several rather extensive human experiments have been carried out using injections of attenuated or killed virus. So far, these have resulted in either simple failure or, in one instance at least, with evidence of rather disastrous results where a supposedly inactive virus may have caused paralysis.

Because of the present conception of immunity, work toward prevention of the disease by sera or vaccines is discouraging though the possibility of success is by no means exhausted. It is quite possible that the immunity that we can detect in the form of circulating antibodies in convalescent serum has little to do with susceptibility or resistance to the disease. Experimentally in monkeys, at least, there seems evidence that only a local immunity is effective, that is an immunity in nerve cells that have already been attacked by the virus of poliomyelitis or possibly have been diseased by some other process. It is possible that poliomyelitis in one part of the central nervous system does not give a systemic general immunity but that another part of the central nervous system may still remain susceptible to an attack by a different pathology. This is apparently the case in monkeys and there are enough cases of two attacks of poliomyelitis in man to suggest that the conclusions from monkey experiments may apply also to the human subject.

I think it is well to point out the great difficulties in the practical use of any biological product for producing immunity even if an effective product were available. These difficulties are inherent in the low incidence of poliomyelitis and in its epidemic character. Since we have no way of identifying a susceptible or resistant individual, any procedure must be carried out on the entire population of a country or of an epidemic area. An average severe epidemic attacks 1 in 1,000 individuals. This is a figure for an epidemic area, not for the country at large. Of these, one in one thousand individuals, perhaps as many as one-fourth with a recognizable disease may get a severe and handicapping paralysis. Therefore, we may say that even if the procedure were limited to epidemic areas we must inoculate perhaps 4,000 individuals to prevent one having a serious paralysis. If we protect only children, the less susceptible adults taking their own risks, this figure would be reduced. If we should attempt such a procedure only in an epidemic area and not try to protect everybody in the country, then we would have to act fast to be effective. As it usually appears in a northern community, we have no good evidence that we are going to have a severe epidemic until well along in the month of July. Since it inevitably takes some time for organization and for the carrying out of our hypothetical procedure and since in most cases of active immunization at least some time must pass between an inoculation and a production of immunity, and since it is probable that infection of an individual has already taken place a week or two before the clinical

evidence of the disease, one can readily see the extreme difficulties in immunizing the community in a single epidemic before most of the victims have been infected. Any procedure which we may later develop must be so extraordinarily safe that the dangers of its application to thousands of individuals must be far less than the chance of one case of serious paralysis.

A great deal of new information has been collected about the way the virus actually gets to the central nervous system in man but up until recently the consensus was that the pathway was either through blood, lymph or spinal fluid as we have mentioned or was similar to that used to inoculate the experimental monkey. Monkeys were successfully inoculated by introduction of virus into their nostrils and the path of the virus through the monkeys' olfactory bulb down to the cord was fairly clear. If first there be injected some sclerosing agent such as zinc sulphate to cause scar tissues in a monkey's nasal mucosa, it was found that thereafter the monkey became resistant to a later intra-nasal inoculation. In the application of this monkey experiment to man it was proposed that the people in an area where poliomyelitis was epidemic be subjected to a similar prophylactic treatment of their nasal mucous membranes by a sclerosing substance to scarify the area and so prevent the passage of the virus to the individual if he should be exposed. Even at the time it seemed an ill-advised experiment to many if one properly considered the risk of cracks and fissures in a scar, the duration of a poliomyelitis epidemic, the low incidence of the disease, etc. However, the public heard of it, a popular medical writer described some preliminary reports with enthusiasm and so a rather extensive clinical experiment was carried out. Luckily for us our friends in Toronto did the work on a good experimental basis and on their own citizens and demonstrated the worthlessness of the procedure very quickly.

This was another example of the danger of trying to apply to man directly something learned by artificial experiments in animals. Since that experience more thorough study of the pathology in man with actual search for the living virus in victims of the disease makes it highly improbable that the virus usually enters the human body by the nasal olfactory nerve route.

Let me summarize now briefly, and therefore a little inaccurately, what I consider the best and latest viewpoint as to the pathogenesis of the disease. It seems most probable that the virus of poliomyelitis goes to the central nervous system by moving along the axon of a peripheral nerve. How it gets to the body and how it makes first contact with a nerve ending is still highly conjectural. It does not get to the central nervous system through the blood, lymphatic system or spinal fluid. It passes through the axon of the nerve apparently causing no damage until it comes to a motor cell in the medulla or the anterior horn of the cord. There it attacks these cells which seem very specifically susceptible and it is probable that it attacks only healthy motor horn cells. A disease process is set up which may cause temporary disfunction or death of certain cells. Secondarily, and dependent upon disease in these anterior horn cells, the inflammatory process in the interstitial tissue of the central nervous system occurs. We have no idea what determines whether a motor horn cell will be diseased enough to die, or to be temporarily functionless but recover, or to entirely escape, but we know that these possibilities exist. If this conception is correct the futility of many of our past efforts at treatment is apparent.

Now we come to a discussion of the Kenny phenomenon which is the latest attempt at therapy and of them all the most popularized by the lay press. It is indeed a phenomenon, and is of great interest in illustrating how we as a nation think and act as well as in its relation to this important disease. First, it demonstrates a commendable open-mindedness that physicians would seriously consider the claims of a nurse completely untrained in medicine or in basic science and from the time she first came to our country most contentious, intolerant of difference of opinion, and filled with a belligerent attitude towards the medical profession. Second, it illustrates what to me at least seems a very unfortunate lack of critical judgment in many physicians, a lack of knowledge of how to evaluate a therapeutic experiment, a lack of knowledge of the natural course of poliomyelitis and a reprehensible tendency, of which, however, physicians are not fully responsible, toward allowing premature publicity. It is hard to resist the fundamental American tendency to ride on the "band wagon," in medicine as in other fields.

This therapeutic venture differs from the others that I know of in that the theory or the ra-

tionale behind the technique followed its application and was developed as an afterthought to explain it. The history of Miss Kenny and her early attempts to cure this disease have been popularized so that I do not need to repeat the story. It is apparent that this very able, energetic, ingenious woman when of necessity left to herself in a difficult situation developed a procedure that seemed to result in the successful care of some patients who apparently suffered from poliomyelitis. Inevitably when she discussed it with doctors, they tried to explain it. These attempts at rationalization have gone on and on. I am not going to take the time to discuss them at length. As more and more inconsistencies appeared the arm chair philosophy to explain them has at times developed to a point of absurdity.

We may consider the Kenny treatment itself as consisting of two major parts:

1. Attempts to prevent pain in muscles with the local application of heat by a very specifically outlined procedure using hot, moist woolen blanket material.

2. The use of most skillful muscle training to re-educate the patient in the use of his affected muscles.

Neither of these procedures, as has often been stated by orthopedists in the past few years, is new in principle; only novel in the intensity of its application and in the fact that the muscle training is carried out earlier in the disease and immobilization used less than most physicians have recommended in the past.

Miss Kenny states that she is dealing with a new disease, one without true flaccid paralysis; that if she can carry out her treatment early enough there is no paralysis or deformity. She claims far less success in patients whom she sees late in the disease and who have been previously treated in what she calls the orthodox manner.

It is hard to summarize the rationale underlying this treatment though it has often been expressed by Miss Kenny and her disciples. Briefly, one conception which Miss Kenny has expressed is that the pathology lies in certain tender muscles, so painful to extension that the contraction of an opponent muscle is inhibited and therefore appears paralyzed though it is not truly paralyzed; therefore, attempts to diminish the pain and tenderness in the one muscle should make the apparent paralysis in the other muscle disappear. According to her concept, to take perhaps the most absurd example, the pharyngeal muscles are inhibited in bulbar poliomyelitis by spasm and tenderness in the muscles of the neck which we have been accustomed to think of as useful to hold our head erect. Relief of muscle pain, therefore, constitutes a primary part of the treatment.

A second concept often expressed is that a victim of the disease forgets how to use a certain muscle, or as she expresses it, is mentally "alienated" from using it, apparently from pain or from what she calls "spasm." Re-education or muscle training constitutes therefore a second essential part of the treatment.

The attempts to construct a theoretical basis for the Kenny concept has directed a great deal of attention to this complex of pain, tenderness, or spasm in poliomyelitis. These symptoms have in turn led to a rather näive rediscovery of the acute interstitial inflammation of the cord and later to a renewal of scrutiny of the acute changes in the other nerve cells than the motor cells of the cord. The questions that have arisen for solution are those related to the establishment of a theory to support the Kenny technique and others arising from renewed interest in muscle function.

Is there any basis for the conception that apparently paralysed muscles are only inhibited or "alienated"?

Is there a relationship between tenderness, so-called spasm, and paralysis?

Is there evidence of a disturbance of the nicety of the reciprocal innervation of a muscle and its opponent that normally causes one to relax as the other contracts?

What is the nature of "spasm"?

Is the pain in poliomyelitis due to disease in the posterior horn cells or in the muscles, or both?

Does rest make any difference in the recovery of diseased anterior horn cells?

We must thank Miss Kenny for furnishing the stimulus for studies, which though so far leading to no very definite answers to our questions, cannot fail to increase our knowledge of muscle function.

From simple clinical observations, it is apparent that there is no good correlation between tenderness, paralysis or even the phenomenon which has been called muscle spasm. Some badly paralyzed patients have little pain and many with much pain have little paralysis. Since some of

the pain can certainly be alleviated by local heat to a muscle, it is evident that disease in the sensory cells of the cord can hardly explain it all. We are still very much confused as to whether the pain due to anterior flexion of the head and neck which is such a constant symptom is the same sort of pain as makes a muscle in an arm sore.

In an attempt to get more objective evidence regarding these points, recent research into this field has made great use of studies of the minute electrical impulses of healthy and partially paralyzed muscles. I must confess that I feel incompetent to do much more than report to you that such studies are being made. Definite answers to most of the questions posed have not yet been made clear, and the nature of the pain and so-called spasm in poliomyelitis is still obscure. Although the study of electro-myograms is still new, I believe one may make these statements:

1. There is no definite evidence of correlation between spasm and paralysis.

2. There are some abnormal electrical impulses arising from many muscles in cases of acute poliomyelitis, impulses which seem to be diminished by the local application of wet heat, but which are not limited to either the tender or spastic or paralyzed muscles.

3. There are other abnormal impulses from partially paralyzed and recovering muscles, but these do not seem to be specific for poliomyelitis, but may be found in other circumstances causing lower motor neurone paralysis.

4. There is evidence from electro-myography that there is indeed a disturbance in reciprocal innovation of the paralyzed muscle and its normal opponent, but we are not sure that this disturbance is specific for poliomyelitis.

The application of all this to treatment is still vague and while awaiting further study we might again recall that the only permanent pathological change that has been recognized in poliomyelitis is the destruction of anterior horn cells. There seems to be no evidence from electro-myography that local heat in muscles can influence paralysis. There is evidence from electro-myography that re-education of a patient in the use of his muscles can be of value, but certainly we have always been sure of this.

How can we evaluate the results of the Kenny treatment? Although this procedure has been used in this country for a number of years with great interest and attention on the part of the medical profession, with the financial support of a great foundation and under the auspices of a medical school, there still exists no good data, no recorded quantitative observations of paralysis to say nothing of an alternate case controlled series than can afford us a certain basis for judgment.

I have outlined to you what steps were necessary to evaluate the serum treatment of poliomyelitis. In my opinion, no less cautious steps can be used to evaluate any other attempt at treatment of this disease that presents itself with such great and spontaneous variations in its course. However, we still have some basis for judgment as time itself gives us experience, though we must resort to unsupported personal opinions. We can ignore theory and only approach the problem as Miss Kenny herself does by looking at results, poorly recorded as they are.

I will refer you to the report in the *Journal of the American Medical Association* for June 17 of this year by the group of orthopedic physicians representing the various orthopedic societies of this country who made extensive investigations into the results of the Kenny treatment. They could find no evidence in support of the idea that the Kenny treatment was an improvement over the usual orthopedic procedures in the past. Why then should any one at any time by simply observing Miss Kenny's work be misled, if they were misled, into thinking that she was accomplishing miracles. In the first place, there seems to be an extensive ignorance on the part of many physicians as to the natural course of this disease. Reports are made giving specific figures as to the per cent of cures in fifty cases, in 100 cases, et cetera. Of course that is no proper way to evaluate results in this disease as there exists such great variation in the degrees of paralysis and in skills in detecting it. Let us go back to the data accumulated from the painful years of the serum treatment when careful quantitative muscle examinations were carried out, something Miss Kenny will not permit on her patients. This data probably represents the best approach to a quantitative estimation of the paralysis in the natural untreated disease. I will use very round figures because results differed somewhat according to different examiners and there is no justification for greater precision since

with increasing skill in early diagnosis more mild and non-paralytic cases are discovered. In general, out of 100 patients seen in the acute stage of the disease with all the usual clinical manifestations, fever, spinal fluid changes, muscle tenderness, stiffness in the back and neck, et cetera, some thirty will get no paralysis detectable by the most skilled and careful muscle examination. I would surmise that perhaps another thirty would have a paralysis too slight to be detected by the average physician. Of the remaining forty, possibly not more than twenty would have a serious degree of paralysis which would permanently handicap them. Of these 100 patients many but by no means all would have some muscle tenderness which would bear no constant relation to paralysis but which would necessitate the most skillful study to detect true paralysis. Practically all would have some tenderness or spasm of the neck and back muscles. Anyone with any experience at all in examining children, and most of these patients are children, knows that it is often impossible to tell whether a child who has soreness of muscle, bone or joint and appears paralyzed is crippled because he will not move or because he cannot move the painful limb.

It is very probable, I think, that the apparent paralysis or weakness seen during the acute stage of poliomyelitis is the sum of at least three different effects: permanent paralysis resulting from irreversible damage to anterior horn cells, temporary paralysis resulting from the temporary loss of function of "sick" anterior horn cells that can recover, a "pseudo-paralysis" resulting from pain or tenderness. That there occurs permanent destruction of motor nerve cells is unfortunately clear enough from pathological study. That the disease can temporarily cause lack of function in a motor cell that will later recover is less easily proved, but seems highly probable from study of the pathology in the monkey. How much of what I call the "pseudo-paralysis" of pain is just that and how much due to incoordinated nerve impulse caused by the acute inflammation in the cord remains to be established.

Therefore much of the initial paralysis in this disease spontaneously disappears, and Miss Kenny and her followers have fallen into the same error of claiming credit for this as their ultimate "cures," as we have done before in many therapeutic trials in this disease. But what about the other cases treated by Miss Kenny and her workers long after the acute stages of the disease? She has seemed to make a long paralyzed muscle move in a way that has impressed all observers. It seems to me very unfortunate that her great skill in what we have long called muscle training has been overshadowed by the unfortunate overemphasis on her treatment in the acute stage and on all the hot packs with their fetish-like application that has been so impressive. Miss Kenny herself claims her best results in the acute stage of the disease and thinks she accomplishes less when she sees her patient later after some physician has treated him. One can well believe that the reverse is true and that she has been misled by her lack of knowledge of the natural course of the untreated disease and that she helps the most in the later stages by her boldness and skill particularly with patients not too well treated previously by physicians.

I think Miss Kenny has done an immense amount of good in spite of some possible harm. Many of us have too long and too completely immobilized partially paralyzed muscles or those we thought paralyzed in the acute stage of the disease and have allowed an atrophy of disuse to occur and have not tried energetically enough to teach our patients to use what muscles they have after very long disuse, either from pain as Miss Kenny emphasizes, or from immobilization. We must defintely acknowledge that the trust we have had in certain time-honored orthopedic principles, such as the importance of long rest of weakened muscles, rests on almost as poor a basis of clinical studies with controlled observations as does Miss Kenny's treatment.

The effect of the personal magnetism or whatever it is that sets apart the healer in the history of all races from others without this dynamic personality, is something that I find quite impossible to evaluate. I wish I had it. But we do not need to resort to mysticism to understand the frequent excellent results of Miss Kenney's personal attention to a victim of poliomyelitis.

I think that epidemics of these last two years have made it very clear that again our people have suffered great disappointment in a treatment at first highly praised. We should look back with criticism of ourselves as physicians for not having demanded that any experimental thera-

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President's Page

The New Year

To our many members in Michigan and those scattered throughout the world, our sincere wish is that the year 1945 will bring them a fullness of health, prosperity and happiness. Although our membership is now in every nation on the globe, let us hope and pray that we may be reunited in 1945.

May the New Year bring to us all, first, the end of the global conflict; second, the unity of our people at home; third, the restoration of our many brothers to their normal pursuits, and finally but most important, the wisdom in our leaders to bring about the successful establishment of permanent peace.

A. S. Brunk

President, Michigan State Medical Society

Editorial

VERNOR M. MOORE, M.D.

■ Vernor M. Moore, M.D., President-Elect of the Michigan State Medical Society, died at his home in Grand Rapids, Saturday, December 30, 1944. The shock of this untimely death leaves us appalled. Dr. Moore attended the Executive Committee of the Council meeting at Detroit, December 14, and appeared in the best of health and spirits, planning his coming administration of the Society and his year of increased service to his beloved profession.

Dr. Moore, as a member of the Council and in the deliberations of the administrative group of the Society, will be sorely missed. He always responded when his advice was needed; his thinking was clear and went through to the ultimate goal.

In the eighty years of our society's existence one other president has died before assuming office. In 1892 Charles J. Lundy, M.D., of Detroit, died before taking office and his Vice President, Gilbert V. Chamberlain, M.D., of Flint, presided.

THIS IS 1945

■ A new Year and a new series of problems are upon us. The past year has witnessed some progress and some heartaches. We lay the past away with mixed feelings of regret for what we failed to accomplish and of satisfaction in measures of real progress that have been taken. The war is progressing satisfactorily, and we begin to see faintly hopes of some of our medical men coming back to take their rightful places in our midst. It has been another year with great labors and great accomplishments in giving medical and surgical care to the civilian population, and to industry, while such a large percentage of our effective members are "away to the wars." The work has been done, and without too much waiting or neglect for the people who were suffering. The Doctors of Medicine have readjusted to their increased duties, and have been able to carry the increased loads with a little more efficiency, and a little less personal strain. They have delivered the goods, without fanfare, and in a most satisfactory manner.

And our members wearing the uniforms of the armed forces. Theirs has been a year of most successful accomplishment. The armies are at death grips, and the casualties are reaching proportions that command attention. Our men who were our confreres and co-workers so short a time ago have shown the world that they are supermen. The work done for the wounded and sick in the far parts of the world has been nothing less than miraculous, and these men whom we considered as good as, and no better than we ourselves have done that tremendous work. The American medical man when given a herculean job to do DOES IT.

We wish all our doctors, abroad or at home, in uniform or out of uniform, the most successful New Year—may its problems bring joy in the solving and contentment in the results.

POLITICAL MEDICINE

■ Do you wish to have someone, a layman, standing at your back and telling you when you can practice medicine, what patients and how many you may care for, what remedies you may prescribe?

Do you wish to be told whether you can practice medicine as a general practitioner, a surgeon, an obstetrician or a neurologist? Do you wish to be assigned to a locality, and told you must practice there?

NO, that is un-American and cannot happen to us in these United States, you say.

Don't be too sure.

Earl Godwin in his broadcast* just recently called attention to the increased tendency in Washington bureaucracies to regiment medicine. He mentioned the fact that several bills are now in Congress, chief among them being the Wagner-Murray-Dingell affair, to bring about government control of medical practice. He warned

*Friday, December 1, 1944.

that renewed efforts will be made in the new congress to further this program. That bill promises services to millions that cannot now be rendered in some parts of the country without relocating members of the profession, and reassigning to them duties that they do not now have.

In Michigan the threat is even closer at home. The proposed amendment to the Constitution of the State will promise to every "normal citizen" complete medical, surgical, obstetrical, dental, pharmaceutical, nursing and hospital care, without charge, and as his right. We know there are not enough practitioners in any one of these fields to give this service as it will be demanded if and when the new plan goes into effect.

The Amendment sets up a Director of Social Insurance who will administer the department, and "shall make such arrangements as it deems advisable with licensed physicians, dentists, and with nonprofit voluntary hospitals, municipal hospitals, county hospitals, state hospitals and university hospitals in order to be able to furnish the medical, dental and hospital benefits contemplated by the amendment." Nonprofit and government hospitals are to be the only ones used. Private hospitals will be out of business.

The political campaign is over and the visionaries who have spotlighted the drive to federalize medicine have been returned to office with what they call a landslide. Is it to be expected that they will be any the less insistent on their program? The pressure for federalization will be even more forceful. The counteracting of this wave of socializing is the business of EVERY MEMBER of the medical profession unless the questions like those above are to be answered in the affirmative.

The only way to influence people is to tell them your views. There cannot be too many contacts with the men who must do the voting to put this program into effect. They are YOUR Congressmen, and are supposed to do *your* will. *Start your important contacts TODAY.*

Michigan's Contribution

During the year just passed Michigan has offered two contributions to the war against political medicine. We have placed Michigan Medical Service on a sound financial basis. We have proved that plans offered and operated by the profession can be successful, and that we have something to offer that meets the needs proposed to be covered by government interference. Studies are in progress to determine the terms under which we can offer increased benefits. One person out of every eight in the state is covered by Michigan Medical service certificates, and one out of every five is covered by Michigan Hospital Service, in which fact the profession can take its full share of pride. These two plans are the result of Michigan's efforts, and our profession had its full share in their progress.

During the year just passed we have established the Michigan Health Council and taken a public opinion survey which shows the sentiment in Michigan much more favorable than the famous *Fortune Magazine* survey, or the California State Medical Society survey. Results of this survey have been published in the November JOURNAL, and comments appear in our editorial pages. We solicit constructive comments from our members, now that they have had an opportunity to read the reports. Lessons have been pointed out and suggestions made to correct some of the unfavorable opinions expressed in the report. Every member should study this survey with his own interests at heart, and should make whatever adjustments he may determine should be made. There is no reason that the public opinion of our profession should not be 99.44 per cent perfect.

The Michigan State Medical Society recently completed a series of five-minute radio dramas over a network covering the entire state, setting forth incidents encountered in the life of a doctor and how he helps in the building of health and happiness in our people. It was the work of professional radio dramatists and writers, produced by a well-known advertising agency. This was in furtherance of the direction of the House of Delegates of the Michigan State Medical Society in promoting good public relations.

We are not too keen on New Year's resolutions—they are too fleeting. As a society we have kept the faith. As individuals we have also kept our efforts in the right direction. May the whole profession continue to give of their very best to the promotion of good health of our people. Such service from each of us will stay political medicine. It thrives where there is dissatisfaction, and only there.

A NATION-WIDE HEALTH PROGRAM

■ A release has come from the office of Dr. Michael M. Davis, chairman, "Committee on Research in Medical Economics," we quote:

"Concerned with *how to distribute the best kind of medical care* to the people of this country, a group of physicians joined forces a year ago with a group of economists and administrators, whose main purpose was *how to pay for this care.* Working together as a Health Program Conference, they have formulated a new nation-wide health program. It differs significantly from other such proposals in bringing together the medical and financial aims. Moreover the plan represents the joint and unanimous conclusions of 29 men and women of widely varying interests. Thirteen of the conference members are physicians, some in private practice, others from universities, health agencies or hospital administration."

"A basic condition of the plan is the protection of the physician in his right to accept or reject patients and to take part or not in a publicly established system." "The plan assures patients the right to choose their own doctors and hospitals. It also safeguards existing hospitals, clinics and voluntary health insurance plans which meet acceptable standards, in their right to supply services and to take part in the system." "The conference proposes comprehensive services."

"In order that comprehensive service shall be available to all, or most, of the population and in order to minimize the administrative costs of acquiring members it is essential that financial participation in the system be required by law."

"The national health program should include general tax funds from the start, especially to aid (a) new or improved hospitals and health centers, particularly in rural areas, (b) the further extension of full-time health departments and other preventive measures, so that every part of the country will be served thereby, and (c) the provision or improvement of medical services to those dependent and other persons not directly covered by the insurance systems."

"Group medical practice is to be encouraged." "Hospitals should come to function as medical service centers, offering preventive, diagnostic and treatment services for bed, ambulatory and home patients and providing office facilities for the physicians on their staffs."

"The principles would permit fees for service, but would tend to encourage the compensation of general practitioners by the capitation or salary method."

This report is a 36-page booklet and fails to say who appointed the Committee on Research in Medical Economics. It states that "thirteen are physicians, some in private practice." A study of the list shows four are members of the "Committee of Physicians for the Improvement of Medical Care" which came into prominence by self-appointment some time ago to speak for the profession in adverse criticism of the profession during the time of the Supreme Court hearings. Three are Federal government employes, two are hospital administrators, one represents a great Foundation, one is director of "Medical Administration Service," and one, who could be in private practice, is chairman, Physician's Forum. This does not sound like a true or just representation of the medical profession. Of the sixteen other members of this Committee ten are government officials and four are members of the Board of the American Association for Social Security. Two represent Labor, five are professors of Economics. Some of these hold two classifications.

This plan or system as they call it is about as desirable in the administration of medical care to the public as is the Wagner-Murray-Dingell atrocity. The lengths to which those long-haired dreamers and star gazers will go to socialize and regiment medicine is just dawning upon us.

To remove the taste of this splurge from your mouth read the fine Editorial in the *Saturday Evening Post* for December 9, 1944. To quote:

"If anything like the Murray-Wagner-Dingell Social Security Bill passes doctors will become state job holders with no more personal interest in your tonsils than could be expected of the clerk of bills at the city hall."

"Your family doctor, who is wearing himself out by his efforts to spread medical care as far as he can, thinks that his number is up. Right or wrong this is what most doctors think, and if you doubt it, the thing to do is ask your doctor."

"We are approaching a day when physicians will be merely a class of skilled laborers, readily hired and fired by their community medical centers."

"The patients never wanted state medicine anyway, but only some sort of prepayment scheme which would make it possible for a man of modest income to pay his own medical bills. Actually the doctors want this too. They welcome patients who carry health insurance and many of them encourage and participate in group insurance and group medical plans."

ADVANCE IN THE PREVENTION AND TREATMENT OF POLIOMYELITIS

(Continued from Page 66)

peutic attempt be properly recorded and quantitated and that proper control cases be chosen for comparison, and also with some humility that the challenge of this nurse has been necessary to stimulate long-needed research in muscle function and a fresh evaluation of our own intrenched orthopedic habits by more critical clinical studies.

MICHIGAN STATE MEDICAL SOCIETY

Seventy-ninth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Pantlind Hotel, Grand Rapids, Michigan

(Continued from December issue)

X. Constitutional Amendments Presented in 1943

Referred to that Committee are those matters on amendments to the constitution that were presented last year and referred to this year's House of Delegates. You will find them on page 18, 19, 20 and 21 of your Handbook.

Article III, Sec. 4—Associate Member for Physicians in Service

Article III, Sec. 4—Memberships for Physicians Temporarily Retired

Article III, Sec. 8—Life Membership

Article VIII, Sec. 2—Succession of President-Elect

Article VII, Sec. 4—Membership for Physicians Temporarily Retired.

Are there other resolutions?

C. E. SIMPSON, M.D. (Wayne): Mr. Speaker, the Council of the Wayne County Medical Society wishes the House of Delegates to make changes in the membership affecting two of our older members. It comes in the form of these two brief resolutions from the Wayne County Society:

VIII—2. SPECIAL MEMBERSHIPS (EMERITUS-RETIRED)

Resolution No. 8 was presented by C. E. Simpson, M.D., of Wayne.

WHEREAS, Emil Amberg, M.D., of Detroit, is an honor member of the Wayne County Medical Society and has engaged in the active practice of medicine for fifty years, and

WHEREAS, Dr. Amberg has been a member of the Michigan State Medical Society in good standing for well over the twenty-five years as prescribed in the By-laws, and

WHEREAS, Dr. Amberg has maintained an ethical practice and contributed greatly to the welfare of the public and the advancement of the profession, particularly as a distinguished leader for the Detroit League for the Hard of Hearing, and

WHEREAS, The Council of the Wayne County Medical Society recommends that he be favorably considered for Emeritus Membership in the Michigan State Medical Society; therefore be it

RESOLVED, that Emil Amberg, M.D., of Detroit, Michigan, be elected by this House of Delegates to Emeritus Membership in the Michigan State Medical Society.

Resolution No. 9 was presented by C. E. Simpson, M.D., of Wayne.

WHEREAS, George M. Livingston, M.D., of Detroit, Michigan, has retired from the acting practice of medicine, and

WHEREAS, Dr. Livingston was born in 1867, was graduated from the University of Michigan in 1898, and has long served the community and his medical societies with skill and dignity, and

WHEREAS, The Council of the Wayne County Medical Society has accredited Dr. Livingston with special membership recognition; therefore be it

RESOLVED, that the name of George M. Livingston, M.D., of Detroit, Michigan, be placed on the list of retired members of the Michigan State Medical Society.

THE SPEAKER: Thank you. These resolutions will be referred to the Reference Committee on Resolutions. Are there further resolutions?

F. H. DRUMMOND, M.D. (Bay): I have four resolutions I would like to present at this time:

Resolution No. 10 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, E. C. Warren, M.D., Bay City, has practiced medicine since 1900, and

WHEREAS, Dr. Warren has been a member of the Bay County Medical Society and the Michigan State Medical Society since 1917, and

WHEREAS, Dr. Warren has been accorded Emeritus Membership by the Bay County Medical Society, therefore

BE IT RESOLVED, that Dr. E. C. Warren be accorded Emeritus Membership by the Michigan State Medical Society.

Resolution No. 11 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, V. L. Tupper, M.D., Bay City, Michigan, has been in practice since 1896, and

WHEREAS, he has been a member of the Michigan State Medical Society since 1906, and

WHEREAS, he has retired from the practice of medicine, and

WHEREAS, the Bay County Medical Society has accorded Dr. Tupper "Retired Membership" therefore,

BE IT RESOLVED, that the Michigan State Medical Society concur in according Retired Membership to Dr. V. L. Tupper.

Resolution No. 12 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, William Kerr, M.D., Bay City, has practiced medicine over 50 years, and

WHEREAS, Doctor Kerr has been a member of the Bay County Medical Society and the Michigan State Medical Society over 25 years, and

WHEREAS, Dr. Kerr has been accorded Emeritus Membership by the Bay County Medical Society, therefore

BE IT RESOLVED, that Doctor William Kerr be accorded Emeritus Membership by the Michigan State Medical Society.

Resolution No. 13 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, V. L. Tupper, M.D., Bay City, has fulfilled all the requirements for affiliate fellowship in the American Medical Association,

BE IT RESOLVED, that the Michigan State Medical Society recommend to the American Medical Association that Dr. V. L. Tupper be awarded an Affiliate Fellowship in the American Medical Association.

THE SPEAKER: Thank you, Dr. Drummond. These will be referred to the Reference Committee on Resolutions.

H. F. Dibble, M.D. (Wayne): Mr. Speaker, I have one resolution to present.

VIII-3. STUDY OF MEDICAL PRACTICE PROCEDURES IN NEBRASKA, CALIFORNIA AND NEW JERSEY

Resolution No. 14 was presented by H. F. Dibble, M.D., of Wayne.

WHEREAS, it appears that many osteopaths are prescribing drugs and practicing therapeutics in violation of Act 162 of the Public Acts of 1903, and

WHEREAS, such violations of the laws of the State of Michigan are detrimental to the *public health* and *welfare*, therefore be it

RESOLVED, that when the present emergency ceases, steps be taken to clarify the *status* of osteopaths, particularly in regard to the practice of therapeutics, and

BE IT FURTHER RESOLVED, that as the preliminary step, the *judicial decision* of the Supreme Court of Nebraska defining the limits of osteopathy, and the action of the State medical societies of California and New Jersey toward absorbing the Osteopaths, *be studied.*

THE SPEAKER: Thank you, Dr. Dibble. This will be referred to the Reference Committee on Resolutions and as a little bait to get you all here at ten o'clock tomorrow morning, one of the first we have will be a brief talk by M. C. Smith, the Executive Secretary of Nebraska, who will talk on this particular problem. Are there further resolutions?

R. H. PINO, M.D. (Wayne): I think it is a good thing not to mix up the resolutions that come from any one county or any other place. It happens I didn't know about the resolution Dr. Dibble just presented and in coming up this afternoon, this subject came under a great deal of discussion and another method of attack was suggested so we have a resolution on that point. Now, this can be taken into consideration by the Resolutions Committee and added or detracted. We are not in disagreement in the matter.

VIII-4. QUALIFICATIONS OF PRACTITIONERS OF DRUG THERAPY

Resolution No. 15 was presented by R. H. Pino, M.D., of Wayne.

WHEREAS, all comprehensive practice of the healing art by individuals who profess to use medicine and surgery includes the use of chemicals, drugs and biologicals which if not skillfully administered may become dangerous to individuals and the public health,

BE IT RESOLVED, that any practitioner or group of practitioners of the healing art who use such chemicals, drugs or biologicals must pass a common Board of Examiners named by the State and acceptable to the Department of Medical Therapeutics of the universities of Michigan.

BE IT FURTHER RESOLVED, that the Michigan State Medical Society through its Council and Legislative Committee give consideration to the promotion of such legislation.

Resolution No. 15a was presented by R. H. Pino, M.D., of Wayne.

WHEREAS, a recent Selective Service ruling provides that there shall be no deferments for pre-medical and medical students not enrolled in medical schools by July 1, 1944;

WHEREAS, this ruling will reduce entering classes in 1945 by about 30 per cent thus drastically curtailing medical classes;

WHEREAS, many such pre-medical and medical students would necessarily be physically disqualified men or women;

WHEREAS, it is obvious that the number qualified would be entirely inadequate to meet the needs of medical care in this country during the next decade;

WHEREAS, many young medical officers will be detained in the Army and Navy and Air Corps for some time following the war thus adding to the deficit;

WHEREAS, appeal to the Army and Navy and President of the United States by the AMA have been unproductive of results; be it therefore,

RESOLVED, that an appeal be made directly to the members of Congress from Michigan by the Michigan State Medical Society urging these members of Congress to take cognizance of a situation that inevitably will reduce the numbers of Doctors of Medicine in the United States to the point where medical care will be reduced far below necessary standards required to maintain safety of health care not alone from the standpoint of contagion but in all other aspects of health.

BE IT FURTHER RESOLVED, that the office of the Society implement this resolution.

THE SPEAKER: Thank you, Dr. Pino. You will have ample opportunity to discuss it tomorrow and you have the right and you are invited to go to the Resolutions Committee.

Any further resolutions?

VIII—2. SPECIAL MEMBERSHIP

Resolution No. 16 was presented by John J. Walch, M.D., of the Delta-Schoolcraft Medical Society.

WHEREAS, Dr. Nancy Rodger Chenoweth has been a member of the Delta-Schoolcraft County and the Michigan State Medical Societies for thirty-two years and has practiced medicine for fifty years, be it

RESOLVED, that she should be given Emeritus Membership in the Michigan State Medical Society.

THE SPEAKER: This will be referred to the Committee on Resolutions.

Resolution No. 17 was presented by J. J. O'Meara, M.D., of Jackson.

At a meeting of the Jackson County Medical Society on May 24, 1944, the following motion was presented and carried. It was moved by J. J. O'Meara, M.D., and seconded by C. S. Clark, M.D., that the Jackson County Medical Society hereby instruct its delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of William W. Lathrop, M.D., of Jackson to said House of Delegates for Member Emeritus; motion carried.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions. Are there further resolutions?

Resolution No. 18 was presented by L. C. Harvie, M.D., of Saginaw.

WHEREAS, Dr. Arthur Grigg is a member in good standing of the Saginaw County Medical Society and the Michigan State Medical Society and has been in practice for fifty years, therefore,

BE IT RESOLVED, that the House of Delegates award him an Emeritus Membership.

THE SPEAKER: This will be referred to the Committee on Resolutions.

VIII—5. COMMENDATION OF MMS ADMINISTRATION

Resolution No. 19 was presented by G. L. McClellan, M.D., of Wayne.

WHEREAS, Michigan Medical Service has provided the means whereby several hundred thousand people of this state have been able to secure medical care on a prepaid budgeted basis, and whereas this medical care has been rendered in a manner which has been generally highly satisfactory to both patient and physician, and whereas this has resulted in better feeling and understanding between the public and the medical profession, and

WHEREAS, the present management of Michigan Medical Service has made a splendid record in financially rehabilitating the corporation and in harmonizing differences,

BE IT RESOLVED, that we, the members of the House of Delegates of the Michigan State Medical Society in meeting assembled this 25th day of September, 1944, wholeheartedly commend the chairman, and its officers and directors of Michigan Medical Service for their splendid achievement, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the AMA and to each County Society and a suitable copy to each officer and member of the Board of Directors of Michigan Medical Service.

THE SPEAKER: This will be referred to the Committee on Medical Service.

VIII—2. SPECIAL MEMBERSHIPS

Resolutions No. 20, 20A and 21 were presented by A. T. Hafford, M.D., of Calhoun.

WHEREAS, Dr. J. Holes has been a member in good standing of the Calhoun County Medical Society for over forty years and has retired from active practice,

BE IT RESOLVED that he be elected to retired membership in the Michigan State Medical Society.

WHEREAS, Dr. Paul Roth has been a member in good standing of the Calhoun County Medical Society for over forty years and has retired from active practice,

BE IT RESOLVED that he be elected to retired membership in the Michigan State Medical Society.

WHEREAS, Dr. Bertha Moshier has been a member in good standing of the Calhoun County Medical Society for over forty years and has retired from active practice,

BE IT RESOLVED, that she be elected to retired membership in the Michigan State Medical Society.

THE SPEAKER: These will also be referred to the Resolutions Committee.

VIII—6. RECOMMENDING VARIOUS STUDIES TO MICHIGAN MEDICAL SERVICE

Resolution No. 22 was presented by S. W. Insley, M.D., of Wayne.

WHEREAS, the Michigan State Medical Society has always been in the vanguard of leadership in matters pertaining to public health responsibilities and,

WHEREAS, the Michigan State Medical Society was the original sponsor of Michigan Medical Service some years back and,

WHEREAS, Michigan Medical Service has by this date demonstrated its physical and financial soundness in its present scope of activities, therefore,

BE IT RESOLVED, that the Michigan State Medical Society now request the Michigan Medical Service to make appropriate studies with the ultimate aim of further improving its usefulness by integrating the numerous health services now being offered by various public and semi-public agencies.

THE SPEAKER: That also goes to the Committee on Resolutions.

VIII-7. CONDENSING HOUSE OF DELEGATES PROCEEDINGS

Resolution No. 23 was presented by T. K. Gruber, M.D., of Wayne.

WHEREAS, a complete stenographic report of every resolution, motion, and word spoken during the Annual Session of the House of Delegates of the Michigan State Medical Society is transcribed and retained in the permanent archives of the Society, available for study by any member of the State Society at any time; and

WHEREAS, a national need exists for saving vital paper stock such as is used in THE JOURNAL of the Michigan State Medical Society; and

WHEREAS, The Council of the Michigan State Medical Society recommends that the considerable expense of publishing every word as spoken before the MSMS House of Delegates in THE JOURNAL be curtailed at this time, if possible; therefore,

BE IT RESOLVED, that the House of Delegates instruct The Council to condense the annual transactions of the House of Delegates as published in THE JOURNAL of the Michigan State Medical Society.

THE SPEAKER: This resolution will be referred to the Committee on Reports of Councils.

VIII-8. ASSESSMENT FOR PUBLIC EDUCATION

Resolution No. 24 was presented by Henry Cook, M.D., of Genesee.

WHEREAS, it appears that the public has not been sufficiently informed as to the serious results of certain movements to change the system of medical care, nor of the deterioration in medical service that will result if such movements materialize,

RESOLVED, that the membership of the Michigan State Medical Society be assessed $10.00 per capita for educational purposes.

THE SPEAKER: Thank you, Dr. Cook. This will go to the Resolutions Committee.

VIII-2. SPECIAL MEMBERSHIPS

Resolution No. 25 was presented by D. J. O'Brien, M.D., of Lapeer.

At a meeting of the Lapeer County Medical Society on August 29, 1944, the following motion was presented and carried. It was moved by Dr. H. B. Zemmer, seconded by C. G. Bishop, M.D., that the Lapeer County Medical Society hereby instruct its Delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of Henry G. Merz, M.D., of Lapeer, to said House of Delegates for Member Emeritus; motion carried.

Resolution No. 26 was presented by D. J. O'Brien, M.D., of Lapeer.

At a meeting of the Lapeer County Medical Society on August 29, 1944, the following motion was presented and carried. It was moved by Dr. H. B. Zemmer, seconded by C. G. Bishop, M.D., that the Lapeer County Medical Society hereby instruct its Delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of David H. Burley, M.D., of Alma, to said House of Delegates for Member Emeritus; motion carried.

THE SPEAKER: Thank you, Dr. O'Brien. They will go to the Committee on Resolutions.

VIII-9. ENDORSING CENTENARY OF NITROUS OXIDE ANESTHESIA

Resolution No. 27 was presented by R. J. Armstrong, M.D., of Kalamazoo.

WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide, therefore be it

RESOLVED, that the House of Delegates of the Michigan State Medical Society commend and endorse the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia.

THE SPEAKER: This will go to the Committee on Resolutions.

VIII-10. RE: EMIC PROGRAM

Resolution No. 28 was presented by L. W. Day, M.D., of Hillsdale.

WHEREAS, the EMIC program was referred to The Council for study, and

WHEREAS, a special committee of The Council was assigned to the task, and

WHEREAS, after many meetings and conferences were held with representatives of the Children's Bureau, health authorities, specialist groups, general practitioners, hospitals and other interested groups, and

WHEREAS, as a result these alternatives were presented by The Council to the profession namely:

(1) Sign the blanks to provide for hospital service, giving professional care gratis; or

(2) Sign the blanks and accept the government fee for medical care; or

(3) Decline to participate in the program, as physicians see fit.

BE IT RESOLVED, that this action of The Council be approved.

THE SPEAKER: Thank you, Dr. Day. That will go to the Committee on Resolutions.

VIII-13. SELECTIVE SERVICE FOR MEDICAL STUDENTS

VIII-2. SPECIAL MEMBERSHIPS

Resolution No. 29 was presented by Alfred LaBine, M.D., of Houghton County.

At a meeting of the Houghton-Baraga-Keweenaw County Medical Society on May 2, 1944, the following motion was presented and carried. It was moved that the Houghton-Baraga-Keweenaw County Medical Society instruct its delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of W. T. S. Gregg, M.D., of Calumet, to said House of Delegates for Member Emeritus; motion carried.

Resolution No. 30 was presented by Alfred LaBine, M.D., of Houghton County.

At a meeting of the Houghton-Baraga-Keweenaw County Medical Society on May 2, 1944, the following motion was presented and carried. It was moved that the Houghton-Baraga-Keweenaw County Medical Society instruct its delegate of the 1944 House of Delegates of the Michigan State Medical Society to present the name of G. F. Brewington, M.D., of Mohawk to said House of Delegates for Member Emeritus; motion carried.

THE SPEAKER: These will go to the Committee on Resolutions. Are there further resolutions? (none)

XI. Reports of Standing Committees

THE SPEAKER: We will go next then, to the Reports of Standing Committees. You will find them listed in order on page 10.

XI-1. LEGISLATIVE COMMITTEE

The Legislative Committee report is printed on page 51 of the Handbook.

The Legislative Committee report will be referred to the Reference Committee on Standing Committees.

XI-2. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

Next is the Committee on Distribution of Medical Care. That report is printed on page 61. Is there a supplemental report? It is referred to the Committee on Standing Committees.

XI-3. REPORT OF REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION

Report of the Representatives to Joint Committee on Health Education is printed on page 58. Is there a supplemental report? If not, it is referred to the Committee on Standing Committees.

XI-4. MEDICAL-LEGAL COMMITTEE

The Committee on Medical-legal Committee report is printed on page 79. Is there a supplemental report? It will be referred to the Committee on Standing Committees.

XI-5. PREVENTIVE MEDICINE COMMITTEE

The Preventive Medicine Committee report is published on page 58. Is there a supplemental report? This also will go to the Committee on Standing Committees. There is a general report by the chairman and then there are all these subcommittees and each one submits a separate report. If there are no supplemental reports on any of these, we will just read them through:

XI-6. Cancer
XI-7. Maternal Health
XI-8. Venereal Disease Control
XI-9. Tuberculosis Control
XI-10. Industrial Health
XI-11. Mental Hygiene
XI-12. Child Welfare
XI-13. Iodized Salt
XI-14. Heart and Degenerative Diseases.

All of these subcommittee reports will be referred to the Reference Committee on Standing Committees.

XI-15. POSTGRADUATE MEDICAL EDUCATION

The Committee on Postgraduate Medical Education. Is there a supplemental report. It will be referred as printed on page 53.

XI-16. PUBLIC RELATIONS

The Committee on Public Relations? Referred as printed on page 72.

XI-17. ETHICS

The Committee on Ethics? That will be referred as printed on page 28.

XII. Reports of Special Committees

Next come the Reports of Special Committees.

XII-1. NURSES' TRAINING SCHOOLS

The Committee on Nurses' Training Schools, as printed on page 51, is referred to the Reference Committee on Special Committees.

XII-2. COM. ON PRELICENSURE MEDICAL EDUCATION

The Conference Committee on Prelicensure Medical Education. That will be referred as printed on page 60.

XII-3. RADIO COMMITTEE

The Radio Committee. Referrred as printed on page 61.

XII-4. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

The Advisory Committee to Woman's Auxiliary. Referred as printed on page 29.

DR. REEDER: As chairman of that committee, I haven't any further written report, but if proper, I would like to say just a word.

DR. REEDER: This Committee of course, consists of three of us who are widely scattered, so therefore, there were no meetings held. However, as Chairman of this Committee, I have taken it upon myself for the past two years to really take an active part, by way of correspondence as well as personal communications with the officers of the Women's Auxiliary. I have found, and I know that you have felt perhaps in the past that the women didn't mean much to us, but I have heard it given little consideration and I want you to know that the Woman's Auxiliary of the Michigan State Medical Society is one of the finest assets we have. They are really getting down to work. They have done some splendid work and their work, particularly in the past two years, should really be commended by this House. It is really marvelous.

The activity they have aroused and the reading they do, I dare say the officers and the committees of the Woman's Auxiliary are reading a great deal more of your MICHIGAN MEDICAL JOURNAL than most of our male members are. They are following the headlines of the newspapers. They are extremely interested in politics and the old saying, "The way to win a man's heart for a woman is to fill his stomach," is not true any more, but she is certainly helping to win over the politicians.

Therefore, I think it behooves us to give the Woman's Auxiliary more consideration, and particularly, I would ask the Council to help them financially when necessary and let us turn in and help them.

THE SPEAKER: Thank you.

XII—5. PROFESSIONAL LIAISON COMMITTEE

The Professional Liaison Committee. There is no report in the Handbook. Is there anyone on that committee who wishes to report? No report.

XII-6. BEAUMONT MEMORIAL COMMITTEE

The Beaumont Memorial Committee. The report is printed on page 50. It will be referred to the Reference Committee on Special Committees.

XII-7. COMMITTEE ON PROCUREMENT AND ASSIGNMENT OF M.D.'s

Committee on Procurement and Assignment of M.D.'s. There are two printed reports by this committee. There is the report of the committee and a supplemental report on pages 76 and 77. If there are no additions, the reports will be referred to the Committee on Standing Committees.

XII—8. JOINT COMMITTEE WITH THE STATE BAR

Report of the Joint Committee with State Bar of Michigan is printed on page 66. Is there a supplement? If not, it will be referred to the Committee on Special Committees.

Now, I would like to make two or three announcements. First, we will meet promptly at ten o'clock after we have our motion to adjourn. As we announced before, tomorrow morning M. C. Smith will speak to us on the problem in Nebraska.

The other announcement is the places of meeting of the reference committees. You will find them on the blackboard. They will meet in ten minutes and if you do not know your chairman, go to that room and he will meet you there.

(The Speaker read the rooms in which committees were to meet.)

THE SPEAKER: I would like to ask, as a special favor, to these delegates here, that those reports all be in by tomorrow morning at ten o'clock insofar as that is physically possible. Probably the Resolutions Committee won't be able to get theirs in by that time because they have a tremendous amount of work to do, but the rest of you, please have your reports ready then.

There are two other things I would like to say. Once

more, the stenographers are in the back of this room. Dr. Foster makes a request that you get your work to the stenographers as early as you can.

A motion to adjourn is in order and we will meet promptly at ten tomorrow morning.

(Upon motion duly made and seconded, it was voted to adjourn until ten o'clock Tuesday morning.)

(The meeting recessed at twenty minutes past eleven o'clock.)

Tuesday Morning Session

September 26, 1944

The meeting convened at ten minutes past ten o'clock with The Speaker presiding.

THE SPEAKER: The House will please come to order. Is the Credentials Chairman ready to report?

J. J. O'MEARA, M.D.: Mr. Speaker: I hold here the credentials of the accredited delegates to the Michigan State Medical Society, of which 50 per cent are not from any one county.

THE SPEAKER: If there are no objections from the House, the Credentials Committee Report will be accepted as the roll call for this meeting.

It is a pleasure this morning to call upon an important individual in medical circles from our sister state of Nebraska, M. C. Smith, Executive Secretary of the Nebraska State Medical Society, who will speak to us on their problem of the osteopath. Mr. Smith.

VII-3. ADDRESS OF M. C. SMITH, NEBRASKA

Already, this morning, I am learning something about Michigan hospitality, and I assure you I am getting to like it.

I am very happy to bring to you officially, the greetings of a sister organization, the Nebraska State Medical Association, whose problems after all, are very much your problems and very much the same.

I have been asked to tell you, in a period of approximately ten minutes, how Nebraska solved its osteopathic problem. I am sure you can see immediately that that will be quite a task, because osteopathy has been a problem ever since the morning of June 22, 1874, at ten o'clock in the morning, when Dr. A. T. Spell received a vision, apparently from on high, whereupon he established the so-called profession of osteopathy.

I can only tell you very briefly what has taken place in Nebraska. Our legal status, as exemplified in our laws, is very similar to yours. In fact, before 1939, you had a better law than Nebraska. You have had some rather bad deals from your Attorney General; interpretations which have given you a situation which brought you down to our level at that time.

In 1941, in our session of the legislature, the osteopaths brought a bill, as a result of the Supreme Court decision in Nebraska, which stated very definitely the activities that osteopaths might pursue in Nebraska, in which they said osteopathic surgery was merely manipulating surgery. They gave us a definite definition of osteopathy, after considerable research, that I am sure is going to stand for a long time to come, and I hope it will help you in your problems.

A bill was presented at that session of our legislature asking that the osteopaths in Nebraska be permitted to practice medicine and surgery on exactly the same basis as a medical man. We were able to defeat that bill, but only by a small margin of three votes. We were advised by members of the legislature that, at the next session, the 1943 session, it would be advisable for us to bring something before the legislature which was constructive rather than continuing attempts to be obstructive in our legislative activities.

Our Committee on Medical Economics started to work shortly after the close of the 1941 session and they spent two years preparing our bill which was LB-139, and I am sure at least some of you are familiar with it.

Our committee started from the ground that if a man is qualified to practice medicine and surgery, he should be permitted to practice medicine and surgery regardless of the school from which he was graduated. Perhaps that is just a little revolutionary thinking, but our committee worked from that basis.

We have had the difficulty, and I am sure you have had the same difficulty, of too many men of this substandard group, who as soon as they received their D. O. degrees, represented themselves to the public and to their patients, as medical doctors. Frequently we meet the statements, as I know you have met them, that they were even better than medical doctors because they had everything a medical school could give them, and in addition, they were osteopaths. We have met that frequently, and therefore, as a part of our bill there was a clause placed therein which stated that every practitioner of the healing art in the State of Nebraska must have at his office, at each entrance to his office, a sign in letters no less than one inch high, giving his name, his degree, if any, and immediately under his name, osteopath, chiropractor, or optometrist. They must place the letters in equal height, showing their particular practice or school from which they graduated.

In other words, most of the medical men in Nebraska had to change their signs where they merely had "Dr. John C. Jones." Our medical men were forced to change their signs to read "John C. Jones, M.D." An osteopath must give his name, "John Doe, D.O.," and then "Osteopath." No longer would the people be taken to an office and given the impression or the idea that they were consulting a medical doctor. If they went to the man's office, they knew they were consulting an osteopath.

We also inserted a registration clause requiring every practitioner of the healing art to register in the county of his practice. We made that quite detailed. He had to give his date of graduation. A special book was provided for each county in the state showing exactly the man's education; when he graduated, the type of education, and also the degree which he held, so that no longer could any individual, not only an osteopath, but any individual, represent himself for something which he was not, because this is a matter of public record and any individual could go to the county courthouse and find that man's history. There is a story behind that provision in our law, but I won't take the time to tell you about it.

Probably the most important feature of our bill, as it is now operating, is the fact that we have set up a new type of registration and educational qualifications. Our examining board now approves the medical schools from which students may be examined in Nebraska. We have run into a little difficulty on that particular point and we are very sorry about it, but it was impossible for us to accept the AMA approval of medical schools and not accept the same thing from the osteopathic schools.

Now, a school, in order that its students may be permitted to take an examination from the Medical Board of Nebraska, must meet certain basic standards as set up by our examining board. Our examining board, therefore, has set qualifications, and in the law, it may not change these qualifications for any particular type of school. The same basic qualifications must apply to all schools. On that basis, then, an osteopathic school that is able to meet the basic standards and basic qualifications of medical education may send its students to Nebraska where they may take the medical examinations, and they are successful in passing, they will receive the same license as a medical doctor receives. That is a little revolutionary.

Also, our State Board of Examiners has been increased from three members to five, which we think is much better. At the present time, we now have the

best medical examining board Nebraska has ever had, and the board assures us that any individual who is able to pass that examination is qualified to practice medicine.

By virtue of the fact that they have a license to practice osteopathy, we have permitted those osteopaths who are now practicing in the state to take the examinations if they make application to the Board prior to July 1, 1948. As a surprising result, at our last examination in December of last year, there were twenty-one osteopaths who took the examination. Of that group, six passed the examination. One man passed with a grade of 83, which is very good. Our board feels that that man should be permitted to practice medicine and surgery in Nebraska, and he now holds such a license. Some of the other men failed miserably.

Our case started from a man who was an osteopath doing surgery in the western part of Nebraska. That particular man in the examinations where one osteopath received a grade of 83, got an average grade of 47. His grade in operative surgery was 27. He, of course, has been weeded out.

At the present time, our situation is such that the osteopaths now in practice may take the examinations, and if they are qualified, they will be permitted to receive a license exactly the same as a medical man. The new men coming in may take the Basic Science Board examination. We still have that. They may take their Osteopathic Board examination if they wish to practice osteopathy.

Our supreme court has definitely defined osteopathy. There is a part of our law which states that a license may be revoked for any practitioner of the healing art who invades another field of that practice. If an osteopath does surgery, he is brought before the examining board, and is not only charged with practicing medicine while being an osteopath, but loses his license.

I wish I had more time to discuss with you the various features of our bill, but I know you are very busy as delegates. I am going to talk to the secretaries tomorrow night and I expect to give a rather brief discussion of how we got into our difficulties and how we got out and how we got our bill passed in the legislature.

THE SPEAKER: Our next order of business is unfinished business.

VIII-11. ENLARGING MMS BENEFITS

Resolution No. 31 was presented by C. F. DeVries, M.D., of Ingham.

WHEREAS, requests have been made of Michigan Medical Service to study various phases of services now provided, and

WHEREAS, the present bed shortage in the hospitals in the various communities of the State is of so serious a nature as to endanger the public health, be it

RESOLVED, that Michigan Medical service be hereby requested to study ways and means of providing for the performance of minor surgery in the physician's office.

THE SPEAKER: Thank you. This resolution will be referred to the Resolutions Committee.

Is there other unfinished business?

VII-4. REMARKS RE: TECHNICAL EXHIBIT

THE SPEAKER: The next item is new business, and the Speaker would like to make an announcement. I shall request that all of you, if possible, visit the special exhibits that are prepared for the delegates at four-thirty this afternoon. You know, there has been a great deal of expense in putting on a meeting of this kind and the expense is borne wholly by the technical exhibit, and it should be viewed by the delegates. This afternoon, there will be no one there but the delegates, so if you can be there at four-thirty, we will certainly appreciate it.

XIII. Reports of Reference Committees

THE SPEAKER: Is there any other new business?

If not, we will go on to the report of the Reference Committees, First, is the Reference Committee on Officers Reports. Dr. Day.

XIII-1. ON OFFICERS' REPORTS
XIII-1 (a) SPEAKER'S ADDRESS

LUTHUR W. DAY, M.D.: The Committee on Officers Reports has reviewed the address of the Speaker and agrees with its contents in principle, with the exception of his third recommendation:

"That in keeping with 'the Declaration of Medical Policies' adopted by this House of Delegates last year, we flatly refuse to participate in any future health program that is inaugurated without first having been submitted to our Society for study and approval."

We would suggest for your consideration that instead of going on record in a statement of what we will not do (which report becomes public property), that it might be better for the Michigan State Medical Society to define a policy stating what it will do.

Mr. Speaker, I move the acceptance of this report as modified.

THE SPEAKER: Is there a second to Dr. Day's motion to accept the report as modified?

(The motion was seconded.)

THE SPEAKER: Is there any discussion?

G. L. MCCLELLAN, M.D. (Wayne): May I ask how the gentleman proposes to modify the report?

DR. DAY: It is modified inasmuch as we take issue with the particular recommendation that has been made to the Speaker. We simply do not approve that recommendation.

THE SPEAKER: Is there further discussion?

R. H. PINO, M.D. (Wayne): We have modified that somewhat for the purpose of discussion. That requires discussion, I believe.

THE SPEAKER: Dr. Pino, will you come up here where they can all hear you?

DR. PINO: There may be a minority report given relative to this. I hope so, because this is not a unanimous report. I heard the discussion this morning which presented both sides of the question as to whether or not the medical profession of Michigan should go on record as saying we will not co-operate with the government. Now, there is a proviso in there, except that we are first consulted, and that sounds reasonable. But, if we were to think that through, we must remember that sometimes we cannot have a thing done for the people that ought to be done. The less we say "We shall not," the better, and that is one side of it.

We may have to meet strikes with strikes. However, for the purpose of discussion, and I am sure the majority of this committee are willing to be persuaded, I wish that there might be opinions expressed to the end that if we say what we will do, it might be a better selling point for the medical profession in the long run.

Dr. McClellan has just asked a question, What is it that this committee proposes we shall do? Well, that is a tremendously big order, and when we strive to do something, you know it takes years to get it to come to pass, but there is one thing we can cite as an example and that is the Michigan Medical Service. We said we would do this, and whether it is as good as we would like to have it, it is something accomplished. At least we can say in answer to the Wagner Act, we believe in this; we will do this.

I wish we might have in mind that things are changing all along the line. We are going to change our minds somewhat, too, about things in general, one way or the other. I believe this Society has the ability to set down things that we will do and not have to say what we won't do. At the same time, I will admit it

may be necessary to meet strikes with strikes, so we place this before you for consideration.

I hope it will be discussed. We are willing to be persuaded.

THE SPEAKER: Thank you, Dr. Pino. Is there further discussion? The motion is that the report be approved with the exception of No. 3 in the recommendations.

F. G. BUESSER, M.D. (Wayne): If I may say so, Mr. Speaker, I think that Dr. Day has not presented this so fully as might be desired. I think before this thing can be definitely discussed that he should incorporate in his report the last paragraph of what the committee decided upon last night. I find myself in a position of being in the minority group. I made the suggestion that the words "flatly refuse" be covered in a little more tactful language. I can well understand, after all these years of association with Dr. Ledwidge, that he has the faculty of expressing his ideas in the strongest possible words. While I don't think we can all be Mr. Somebodies, at least we can take the sting out of something and still not weaken our position.

At this particular time as we approach a very critical period in our history, it seems to me that the House of Delegates of this Society has put on record a very definite and at least startling proposition as to how medical care can be provided for the people of the State of Michigan.

The point I want to make is this: I don't think that we should now, by phrase or by action, indicate to the public that this Society is commencing to weaken its position or stand in connection with so-called state medicine. I think the best defense is its very strong offense, and it is for those reasons that I find myself in this not embarrassing, but at least not enviable position, and that I make these few remarks.

I don't think we want to do anything that is going to weaken our position. We have taken a definite stand in state medicine and I don't think we should commence to retrench.

THE SPEAKER: Thank you for your clarification. May the chairman make one statement? A topic once referred to a reference committee on reports cannot be touched by anybody else until such report is made. It is obvious that there is some difference of opinion on one point among the members of the committee.

The Chair would entertain a substitute motion to refer this matter back to the committee for clarification on point No. 3, such clarification to be in typewritten form as a part of the report. Is there such a motion?

R. A. SPRINGER, M.D. (St. Joseph): I will make such a motion.

H. F. DIBBLE, M.D. (Wayne): I second it.

THE SPEAKER: The motion is that this shall be referred back to the committee on point No. 3, and clarification is to be brought in. Is there any discussion?

R. H. PINO, M.D. (Wayne): Mr. Speaker, suppose all we can say is that we believe that it is better to state what we will do for the public record before it becomes a public record, instead of stating what we will not do?

THE SPEAKER: Correct.

DR. PINO: Does our report not do that? Maybe it does that.

W. N. BRALEY, M.D. (Wayne): I felt that the Speaker's statement did say what we would do. It said we would refuse to co-operate unless the plans were submitted for our approval. I don't think it could be clearer than that.

THE SPEAKER: That is not the committee's report. We want the committee's report clarified. Is there further discussion?

(The question was called for.)

THE SPEAKER: All in favor of the substitute motion to refer this back to the committee for clarification on point No. 3, such clarification to be typewritten, say "aye"; opposed? So ordered.

The next order of business is the continuation of the report.

XIII-1 (b) PRESIDENT'S ADDRESS

LUTHUR W. DAY: Your Committee on Officers Reports has reviewed the report of the President and wishes at this time to compliment him on the efficient management of the President's office and accepts his report.

Mr. Speaker, I move the acceptance of this report.

DR. BAILEY (Wayne): I second it.

THE SPEAKER: All in favor of the motion say "aye"; opposed? The motion is carried.

XIII-1 (c) PRESIDENT-ELECT'S ADDRESS

LUTHUR W. DAY, M.D.: Your Committee on Officers Reports has reviewed the address of the President-Elect and wishes him success during his tenure of office.

Mr. Speaker, I move the acceptance of this address.

C. S. RATIGAN, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? The motion is carried.

XIII-1 (d) REPORT OF DELEGATES TO AMA

LUTHUR W. DAY, M.D.: Your Committee on Officers' Reports has read the report of the Delegates to the American Medical Association in the Blue Book and listened to the Supplemental Report by Doctor Luce and views with alarm the arbitrary attitude of the officers of the American Medical Association toward the Delegates to the American Medical Association of the Michigan State Medical Society.

Your Committee would like an expression of an opinion from our Delegates to the American Medical Association as to what can be done to mitigate this situation.

We wish to express our confidence in the ability and integrity of our Delegates.

Mr. Speaker, I move the acceptance of the Delegates' report.

C. L. HESS, M.D. (Bay): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? So ordered.

XIII-2. ON REPORTS OF THE COUNCIL

THE SPEAKER: The next order of business is the report of the Reference Committee on Report of the Council. Dr. Barrett of Wayne.

W. D. BARRETT, M.D. (Wayne): Your Committee appreciates the amount of work that has been performed by The Council of the Michigan State Medical Society during the past year.

We agree with the report in its entirety as printed in the Handbook with the exception of: On line 3, paragraph 2, page 36, delete, "That our civilian doctors are able to fit" and substitute, "how ably our civilian doctors fitted."

I move the adoption of this correction as given at this time.

THE SPEAKER: The motion is to accept this portion of the report which has been read with the correction that has been passed.

(The motion was seconded.)

THE SPEAKER: Is there any discussion on this motion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BARRETT: While we appreciate the work done by the special committee of The Council on the EMIC Program, yet the committee feels that perhaps further discussion in the House of Delegates should take place before approval of their plan; namely, a, b, c. That if the House of Delegates should not approve the recommendation a, b, c, that we then cease to co-operate with this plan at the end of the specified time; namely, six months after the duration.

I move the adoption of this part of the report.

ARCH WALLS, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? So ordered.

For your information at this time, I am sure the question is coming up for discussion during the reports of one of our committees.

DR. BARRETT: We feel that an expression of thanks from the Michigan State Medical Society to Parke, Davis and Company for their generosity in purchasing the Early House on Mackinac Island, the scene of Beaumont's first experiments, would be a fine gesture.

I so move.

J. B. RIEGER, M.D. (Wayne): I second it.

THE SPEAKER: Is there further discussion? If not, all in favor of accepting this part of the report with the correction, say "aye"; opposed? It is carried.

DR. BARRETT. For the supplemental report of the Committee, the Committee suggests that questionnaire cards in sufficient number be sent to each county society and that the responsibility of returning these signed cards be left to each society.

I move the adoption of this portion of the report.

J. A. KASPER, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BARRETT: We recommend the tabling of the Brasie Resolution of 1943 and that specific authority be granted The Council to test the legal rights of certain practitioners; the test to be timed for the most propitious moment.

I move the adoption of this portion of the report.

F. G. BUESSER, M.D. (Wayne): I second it.

T. K. GRUBER, M.D. (Wayne): I would like to have this statement amplified a little bit.

DR. BARRETT: Section 9 of the Supplemental Report from The Council:

"Brasie Resolution of 1943. A special committee (Sladek, Beck, Riley, Witwer) was appointed by the Council to study and report on this proposal to limit Michigan Medical Service to Doctors of Medicine.

"If this Resolution were adopted, it would put Michigan Medical Service out of business. Michigan's successful program of group medical care cannot survive if such peremptory action is taken at this time. The problem outlined in the Resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve. If you desire Michigan Medical Service, which is our only telling answer to federalization and regimentation, to continue as your bulwark, this resolution should be tabled and in its place specific authority to test the legal rights of certain practitioners—the test to be timed for the most propitious moment—should be granted The Council."

THE SPEAKER: Is there any other discussion?

D. R. BRASIE, M.D. (Genesee): In the first place, I object to the labeling of the Brasie Resolution. As you look back on the minutes of the last meeting, you will see it was introduced as having arisen from the County of Genesee and was not my personal resolution. I would like to see that corrected in the statements that have been made here and in the records. I think that is only right and just.

THE SPEAKER: The Chairman would like to agree with Dr. Brasie on that point. Dr. Brasie is only expressing the viewpoint of the Genesee County and if it is agreeable to the House, those corrections will be made. Is there any objection from the House? (None.)

DR. BRASIE: Further, Mr. Speaker, there has been another statement made here which I did not take up under the report of Dr. Moore. It comes up in this report of the committee. A flat assertion is made that if the osteopaths are excluded from Michigan Medical Service, it will fail and fold up. Gentlemen, that is a flat assertion, not substantiated by any facts. It is not substantiated by anything except the opinion of those men who made it. It should not stand on the records as a statement of fact. It should stand on the records that they wish to put it in as an opinion expressed, if you please.

There are differences of opinion on that subject. This is an opinion, and I think it should be corrected. I won't ask that. I just want it in the records that it is an opinion and cannot stand as a fact. There is no substantiation of it.

Furthermore, the statement was made that the fact that osteopaths now practice under Michigan Medical Service is not the fault of Michigan Medical Service. I take exception to that remark and object to approving this thing as stated. We will have to have a little of the history, very briefly.

There are men in this House who remember that when the Michigan Medical Service proposition was presented, one of its largest sales arguments was that it would exclude the osteopath. That is one of the big things that sold it to some of the men in the state. That was stated by some of the men who are present here today. Within six months after the formation of Michigan Medical Service, they saw fit to yield to pressure. The pressure was that it was having a hard time surviving, the Ford contract was coming up, and the Ford Personnel Division insisted that payment be made to any form of practitioner, and they even paid chiropractors.

Now bear in mind, Michigan Medical Service didn't pay them, but the fees these men charged were deducted from the payment of Ford Motor Company made to Michigan Medical Service, so they could get up before you gentlemen and say, "We didn't do that." They subterfuged. So the records give the denial to the assertions that have been made today. It is in the record. We just want to keep the records straight.

Incidentally, you have a new management that has done very well in many respects. It did not create this precedent, but some of the men on the board that did create it are still on the board, and some of the officers of this Society are still here that helped create it, and the fact should be so recorded.

We have listened to a lot of eyewash on this subject because of fear. Fear! You have heard an address this morning on what was done with the same act that we have in the State of Michigan. I ask that the portion of this Committee's report which refers to the fact or to the alleged fact that it was not the fault of Michigan Medical Service that the osteopaths were included, be deleted. Otherwise, you are not being consistent.

Now, what you do with a situation in the future is not to be discussed here, I understand. We can't go into that. But I ask that that portion of this report of the committee that asserts Michigan Medical Service is not responsible for this condition, being obviously an untruth and not intentional, but perhaps an overlooking of past history, be deleted. I so move. I move that as an amendment to the report.

DR. LOUPEE (Cass): I support the motion.

THE SPEAKER: Is there further discussion?

DR. LUCE (Wayne): As a senior delegate to AMA, I would like to ask a question of Dr. Brasie; would he be content with the acceptance of his first recommendation that the committee make "in our opinion" a deletion.

DR. BRASIE: Dr. Luce, the question of "in our opinion" applied to the one specific statement, "but this resolution would drive Michigan Medical Service out of business." That was a statement of fact, and in that respect, I am content, but as far as including the rest of the report, whitewashing the fact that the Michigan Medical Service allegedly did not do this, I would not be content.

THE SPEAKER: In other words, you do not ask for the deletion of the other part?

DR. BRASIE: I did ask for the deletion of the other part. I asked for the deletion of that portion of the report which states—

THE SPEAKER: You mentioned two things: First was "in our opinion—"

DR. BRASIE: And, you granted that?

THE SPEAKER: No.

DR. BRASIE: I am sorry, but—

THE SPEAKER: You asked that the resolution be changed in the record from your name to representa-

tive of Genesee. Is that correct? Second, you called attention to the fact that the statement that the Michigan Medical Service would fail was opinion only, but you did not ask for the deletion. You were satisfied to have that go on the record.

DR. BRASIE: I was not in error in asking it be made an opinion, but if the Chair pleases, I would prefer that be deleted.

THE SPEAKER: We will act on those things separately. The one now is—I don't recall the exact wording you wish to change. . . .

DR. BRASIE: Perhaps it would be more specific. . . .

THE SPEAKER: That, it was not the fault of the Michigan Medical Service. Do you want to delete that?

DR. BRASIE: I want that statement and the explanation of it deleted.

THE SPEAKER: Will the chairman of the committee read that portion of the report?

DR. BARRETT:

"If this resolution were adopted, it would put Michigan Medical Service out of business. Michigan's successful program of group medical care cannot survive if such peremptory action is taken at this time. The problem outlined in the resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve. If you desire Michigan Medical Service, which is our only telling answer to federalization and regimentation, to continue as your bulwark, this resolution should be tabled and in its place specific authority to test the legal rights of cerain practitioners—the test to be timed for the most propitious moment—should be granted The Council."

DR. BRASIE: I can only legitimately ask that those two sentences at the beginning be deleted; that the following paragraphs which are necessary to the consideration of the resolution be preceded by, "in the opinion of the committee."

THE SPEAKER: Now, Dr. Barrett, will you read that portion again that Dr. Brasie has now mentioned?

DR. BARRETT:

"The problem outlined in the resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve."

DR. BRASIE: Those two sentences only, because they go together. If that is deleted, it doesn't change the sense.

THE SPEAKER: The amendment then, as it is now stated, would be to delete this portion of the report: "The problem outlined in the resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve."

DR. LOUPEE: I second that.

THE SPEAKER: Is there any discussion on the amendment?

R. L. NOVY, M.D. (Wayne): The first two comments Dr. Brasie made in regard to the motion and in regard to the fact of the statement being a question of opinion, are absolutely correct.

The second statement he made is correct and his deletions, I believe, of that portion are proper. I do not wish that there be a motion to carry the implication that the Michigan Medical Service is responsible for the whole problem. It brought the problem to a head. I do not wish to make any comment that Michigan Medical Service in the first couple of months in allowing deductions to be made to the Ford Motor Company for osteopaths was not good. This problem should have been met at that time. It was not met at that time and, as we mentioned to you a year ago, it is a question of that having been established.

I do want ot make sure this motion does not imply that the Michigan Medical Service is responsible for the problem, or rather, I want to say it has brought the problem to a head. I concur in Dr. Brasie's statement with that qualification.

THE SPEAKER: Is there any further discussion on the amendment? All in favor of Dr. Brasie's amendment to delete this portion say "aye"; opposed? The motion is carried.

We have to vote now on the original motion to accept this portion of the report with the amendment. Is there any discussion as to accepting the report as amended? All in favor say "eye"; opposed? It is carried.

DR. BARRETT: We recommend that a bloc be inserted in the Michigan State Medical Society JOURNAL expressing our gratitude for the Biddle bequest.

I move the adoption of this portion of the report.

THE SPEAKER: Is there a second?

B. G. HOLTOM (Calhoun): I second it.

THE SPEAKER: Is there any discussion on this motion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BARRETT: The Committee read the resolution of Dr. Gruber for the recommendation of the Council in the Handbook and moves adoption by the House of Delegates.

Should this resolution be read?

THE SPEAKER: Yes. This is the resolution that came as a part of the recommendation of the Council and therefore was referred to this Committee. It came as the result of the recommendation of the Council and then was referred to this Committee rather than the Resolution Committee.

DR. BARRETT: Resolution No. 23.

"WHEREAS, a complete stenographic report of every resolution, motion, and word spoken during the Annual Session of the House of Delegates of the Michigan State Medical Society is transcribed and retained in the permanent archives of the Society, available for study by any member of the State Society at any time; and

"WHEREAS, a national need exists for saving vital paper stock such as is used in THE JOURNAL of the Michigan State Medical Society, and

"WHEREAS, The Council of the Michigan State Medical Society recommends that the considerable expense of publishing every word as spoken before the MSMS House of Delegates in THE JOURNAL be curtailed at this time if possible, therefore be it

"RESOLVED, that the House of Delegates instruct The Council to condense the annual transactions of the House of Delegates as published in THE JOURNAL of the Michigan State Medical Society."

I recommend the adoption of this resolution.

C. L. HESS, M.D. (Bay): I second the motion.

G. L. MCCLELLAN, M.D. (Wayne): I listened to Dr. Gruber yesterday afternoon, or yesterday evening, condemning the American Medical Association for this very thing. In very stirring language, he aroused us to a state of rebellion. Now, we are asked that the report of the Michigan House of Delegates be curtailed. It seems to me that the same objective might be reached, Mr. Speaker, if we become a little more economically-minded and less scientifically-minded and for an issue or two, let's curtail the space given the membership record and let's have the membership acquainted with what we are doing.

THE SPEAKER: May the Chair attempt to clarify one point? I believe there is this difference: According to this resolution, there would be at all times a transcript of every word spoken here in the Executive Office at Lansing and those records are always open for review by any member of our Society. Is that true of the American Medical Association, Dr. Luce?

DR. LUCE: Mr. Speaker, I believe that is true of the American Medical Association, but if I may be allowed to comment, that doesn't do us any good. It is there, but who reads it?

THE SPEAKER: Do you mean in the American Medical Association or here at home?

DR. LUCE: Both.

THE SPEAKER: Then, without seeming to be argumentative but merely pointing out some of our difficulties, how could a senior delegate to the American Medical Association ask that this be deleted last night?

It is for that very reason that is being done, I assure you, in part. It is not the whole reason, that unless we do have some prerogative for cutting some of this down, it will mean many more executive sessions of the House. Our policy has been, as you know, open house for every member of our Society, so we may all know and become interested in what is going on.

I am not arguing for the members, but for the things that come up. Is there further discussion?

DR. LUCE: Mr. Speaker, may I have the question repeated again for the sake of making the record more clear?

DR. BARRETT:

"That the House of Delegates instruct the Council to condense the annual transactions of the House of Delegates as published in THE JOURNAL of the Michigan State Medical Society."

DR. LUCE: My comments further would be that I have asked that only that portion of my report be deleted. Further if I may at this time make an amendment to that motion, I would say, make an amendment to that motion that this be applicable to the sessions of the year of 1944; this session at the present time as it is now, not to go through all sessions of the future, only the year of 1944.

THE SPEAKER: I don't quite understand you. If I understand what you mean, this would then go into this resolution and it would affect not next year, but this year.

DR. LUCE: I believe the resolution refers to the minutes of this meeting.

THE SPEAKER: You mean this resolution would be incorporated in the handbook as part of our By-Laws?

DR. LUCE: May I ask that, that last for all time?

THE SPEAKER: Until changed by further motion?

DR. LUCE: I would make a motion as an amendment that this particular statement in this resolution be only applicable to this one session of 1944.

THE SPEAKER: Then, no particular date would be referred to.

DR. LUCE: Have it qualify the whole resolution as it now stands. That would be an established policy for the future until further rescinded. I am limiting it to one year's time.

THE SPEAKER: Dr. Luce wishes to offer an amendment to limit this resolution, if passed, to 1944 only.

DR. LUCE: Whether passed or not, I am offering that as an amendment and they can pass it or not, afterwards.

DR. NOVY: How much more would it cost to print the whole thing, and why does Dr. Luce, at this particular time, when things are so crucial, want anything deleted? If it is going to cost $50 more, why—. The whole motion doesn't stand well with the various discussions Dr. Luce had about the American Medical Association.

THE SPEAKER: The Chairman doesn't know, and I am not sure anybody knows how much difference it would make.

DR. NOVY: Are we quibbling about ten dollars or ten cents or ten thousand dollars?

THE SPEAKER: The Chairman refuses to answer that. Dr. Luce may answer the second question.

DR. LUCE: May I have the question repeated?

THE SPEAKER: Dr. Novy, do you wish to repeat that part?

DR. NOVY: I would like Dr. Luce to answer me at this time, why, when we are so much interested in all the transactions that are going on, he is anxious to save the paper and fifty dollars or fifty cents, or whatever it may be, for us just this one year, setting aside the very thing he spoke so well about, that everybody be thoroughly acquainted in every respect with what goes on. It seems to me that this is more important than the idea of saving a little paper and changing temporarily the very principles you fought for yesterday on the floor.

DR. LUCE: Mr. Speaker, I think I am being identified as the sponsor of the motion, which I am not. I would like to say, Mr. Speaker, that if anybody else uses the word "critical" here during this session, I am going to leave the session.

DR. GRUBER: This has been tied to me. The resolution came from the Council and we in the Council of the Wayne County Medical Society are not in a position to enter resolutions. They had considered the situation and felt they would like to conserve paper and maybe a few nickels, and I was asked to introduce the resolution. I have no feeling one way or the other. I simply brought it to the attention of the House of Delegates at the request of the Council. It is the judgment of the Council that this should be done. I am not going to say what my judgment is going to be. I will vote on the subject, but I do it just as a favor to the Council of the Wayne County Medical Society.

THE SPEAKER: Thank you, Dr. Gruber. I would like to substantiate that statement Dr. Gruber has made. This was a recommendation of the Council. This requires a resolution to bring it before the House. The Council is not in a position to make resolutions. Therefore, Dr. Gruber presented it, for which he has suffered.

I told you a moment ago that saving the paper was in part the reason for this. I would like now to call on Dr. Foster to amplify the reasons for this.

THE SECRETARY: Mr. Speaker, a number of factors enter into this, I believe, and the first one is, there are certain postal regulations that there must be as much reading material in THE JOURNAL as advertising material. THE JOURNAL for a long time, has been going into the red, as you know from the financial report. A dollar and fifty cents from your dues has been allocated to THE JOURNAL which shows up as a source of revenue.

However, for the last year, THE JOURNAL has made a definite profit by so meeting the problems of reading material in contrast to the advertising material which has increased tremendously. That is not the only point.

The second point refers to requests of members who desire to speak here "off the record."

DR. BRASIE: There are other ways of deleting that which should not go into the records. You can go into an executive session or it can be deleted from the records at the discretion of the House.

THE SPEAKER: I might say we are rather off-color, all of us. We really should be discussing Dr. Luce's amendment. So let's confine our discussion to that part for the moment.

Dr. Luce's amendment was, this resolution be so amended as to apply to the year 1944 only. Is there further discussion on Dr. Luce's amendment?

F. J. O'DONNELL, M.D. (Alpena): I was going to offer this as a suggestion or as a question, whether it wouldn't be possible that before you stated the transcript of the record would be in the state office prior to our organization, why a short digest of the doings of the House of Delegates could not be published in THE JOURNAL and a mimeographed copy of the exact word-for-word proceedings transmitted to the secretary of every county medical society so we will have it in our hands if we want it.

THE SPEAKER: You are out of order, but your discussion is good. We will take it up when we finish the other.

(The question was called for).

THE SPEAKER: All in favor of Dr. Luce's amendment say "aye"; opposed "no." I believe we will have to take a standing vote. All those in favor of Dr. Luce's amendment please rise. (Eighteen members arose.)

All those opposed, please rise. The motion is lost.

Now, we are ready for further discussion on Dr. Barrett's motion to pass this resolution which is giving the Secretary the right to condense the proceedings of the House as published in THE JOURNAL.

R. S. BREAKEY, M.D. (Ingham): This vote on the present motion is that there shall be no condensation, is that right?

THE SPEAKER: Correct. Is there further discussion?

R. J. ARMSTRONG, M.D. (Kalamazoo): I would judge by the vote on the amendment that there is confusion in the House. If you pass this thing, don't let it go longer than a year, for the sake of freedom. Let's deny this motion.

THE SPEAKER: Thank you. The point has already been settled. It wouldn't apply just for this year, so it is only a question now of this resolution.

R. A. JOHNSON, M.D. (Wayne): I would like to ask whether it has been the policy in the past to make deletions on the deliberations of this body?

THE SPEAKER: I think I will ask the Secretary that, although I think I can answer it myself.

THE SECRETARY: The transcript that will result from the stenotypist's notes will total about 256 pages a year. It takes three days to edit them. Bill Burns and I spent three days completely in the editing of these. If they were published as they came back, many members of the House would hate to see in writing what they ad lib from this platform, and I will say frankly, there have been many paragraphs deleted; not because of their context, but because of the way the case was stated, and the English used, but there has never been a deletion of action or opinions expressed. However, there have been pages of deletions of words. As to the point I made a minute ago of concealing anything, I would like, if I may, Mr. Speaker, in justification to the Executive Officers, say that the secretaries have not concealed anything.

My statement was, I believe, that this was presented by Dr. Luce because he asked that it not be published for that reason. The secretaries have no discretion in concealing anything. They simply carry out duties and there has been no concealing on the part of the secretaries.

DR. JOHNSON: Would this present vote now before the House change that?

THE SPEAKER: Yes, it definitely would. That is, if I understand it correctly.

R. V. WALKER, M.D. (Wayne): It seems to me there are two things here. One is the saving of space and the other is the question of publicity. The subscription list of THE JOURNAL is open not only to members of the Michigan State Medical Society, but to any one who will purchase THE JOURNAL; it is a matter of keeping this from the general public. There are things here which possibly should not go to the osteopaths, as for instance, the motions that are going to take place at the proper time. Those would all be sent to the membership of the medical societies if the proceedings were published as a separate issue and sent only to the members and not the subscription list of THE JOURNAL.

THE SPEAKER: Is there further discussion?

(The question was called for).

DR. ARMSTRONG: I don't think we need to worry about any publicity. The short time I have been in politics, it has always got out before I left the hall. There is always somebody to tell the opposition.

As far as saving paper, the records are kept in Lansing. We would have to spend gas to go up there. What do you want to do—save paper or save gasoline?

THE SPEAKER: Are you ready for the question?

(The question was called for).

THE SPEAKER: The question is on the motion as presented by Dr. Barrett, chairman of the committee, to give power to delete from the transcript as published in THE JOURNAL. All in favor of the motion say "aye"; opposed "no." The noes have it.

DR. LOUPEE: May I ask for a ruling?

THE SPEAKER: Yes.

DR. LOUPEE: As a result of this vote, does it now mean the secretaries have no right to delete a single word that is expressed here, or do they have a right to edit these reports?

THE SPEAKER: It is the understanding of the Chair, the procedure will be the same as it has been before. Is that the understanding of the House? (Agreed.)

DR. BARRETT: I move the adoption of The Council Report, as amended.

(The motion was seconded).

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed "no." The motion is passed.

The next order of business is the report of the Reference Committee on Standing Committees. Dr. Donald Beaver of Wayne.

XIII-3. ON STANDING COMMITTEE REPORTS

DONALD BEAVER, M.D. (Wayne): The Reference Committee on Reports of Standing Committees met in Room 126, Pantlind Hotel, September 25, 1944.

Those present were: M. G. Becker, M.D., Milton A. Darling, M.D., R. T. Lossman, M.D., W. B. Harm, M.D., F. J. O'Donnell, M.D., Carl Ratigan, M.D., and Donald C. Beaver, M.D., chairman.

The annual reports of each of the standing committees for 1944 were carefully considered and the following actions were adopted:

The report of the Legislative Committee was approved as published in the Handbook, page 51.

Mr. Speaker, I move the adoption of this committee's report.

A. E. STICKLEY, M.D. (Ottawa): I second it.

THE SPEAKER: Is there any discussion on this part of the report? All in favor say "aye"; opposed? Carried.

DR. BEAVER: The Report of the Committee on Distribution of Medical Care was approved as published in the Handbook, page 61.

Mr. Speaker, I move the adoption of this committee's report.

CARL RATIGAN, M.D., (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? The motion is carried.

DR. BEAVER: The report of the representatives to the Joint Committee on Health Education was approved as published in the Handbook, page 58, with the notation that this committee be urged to carry out the recommendations which it had made.

I move the adoption of the committee's report with the changes made by the committee.

THE SPEAKER: The only changes are to carry out the recommendations.

J. A. KASPER, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion. The motion is to accept this report plus the recommendation of the Reference Committee that they carry out their own recommendations.

All in favor say "aye"; opposed? Carried.

DR. BEAVER: The report of the Medical-Legal Committee was approved as published in the Handoook, page 79.

I move the adoption of this committee's report.

ARCH WALLS, M.D. (Wayne): I second it.

THE SPEAKER: All in favor of the motion say "aye"; opposed "no." Carried.

DR. BEAVER: The report of the Preventive Medicine Committee was approved as published in the Handbook, page 58.

Mr. Speaker, I move the adoption of this committee's report.

DR. JOHNSON (Wayne): I second it.

THE SPEAKER: All in favor of this motion say "aye"; opposed? Carried.

DR. BEAVER: The Committee on Preventive Medicine is divided into nine subdivisions and each of these subcommittees' reports were acted upon as well. I will now begin the reporting of the various committees.

First, is the Cancer Committee. The Reference Committee recommended that the Cancer Control Committee be highly commended for its constructive work in the publishing of the *Cancer Manual* and that a broader distribution of the *Manual* be attempted amongst doctors of medicine, nurses, and social workers as suggested in the Committee's report and that the entire report of the committee be approved as published in the Handbook, page 49.

Mr. Speaker, I move the adoption of the recommendation of the Reference Committee and the changes made by the Reference Committee on the report of the Cancer Control Committee.

DR. WALLS (Wayne): I second it.

THE SPEAKER: Is there any discussion on this point? All in favor, please say "aye"; opposed? It is carried.

DR. BEAVER: Now, I would move that the reports of all the other standing committees be accepted as published in the Handbook.

DR. RATIGAN (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? It is carried.

Thank you, Dr. Beaver. The next order of business then, is the report of the Reference Committee on Special Committees. Dr. E. A. Oakes will please take the Chair.

(The Vice-Speaker assumed the Chair).

XIII-4. ON REPORTS OF SPECIAL COMMITTEES

A. V. WENGER, M.D. (Kent): Your Reference Committee commends the various special committees on the tremendous tasks well done in the preparation of their reports as printed in the Handbook. The first report is the report of the Committee on Nurses' Training Schools. The Committee approves the report as printed in the Handbook on page 51.

Mr. Speaker, I move the adoption of the report.

THE CHAIRMAN: Is there a second?

(The motion was seconded).

THE CHAIRMAN: All in favor say "aye"; opposed "no." It is carried.

DR. WENGER: The Report of the Conference Committee on Prelicensure Medical Education. The Committee approves the report as printed in the Handbook.

I move the adoption of this report.

J. O. WETZEL, M.D. (Ingham): I second it.

THE CHAIRMAN: Is there any discussion? All in favor respond by saying "aye"; opposed "no." Carried.

DR. WENGER: The third is the report of the Radio Committee. The Committee approves the report as printed in the Handbook.

Mr. Speaker, I move the adoption of the report.

THE CHAIRMAN: Do I hear a second?

J. J. O'MEARA, M.D. (Jackson): I second it.

THE CHAIRMAN: Is there any discussion? If not, all in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Advisory Committee to the Woman's Auxiliary, together with the supplemental report made orally by Dr. Reeder, chairman of the committee. The Committee approves the report as printed in the Handbook.

Mr. Chairman, I move the adoption of the report.

ALFRED LABINE, M.D. (Houghton): I second the motion.

THE CHAIRMAN: Is there any discussion? If not, all in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Beaumont Memorial Committee. That is found on page 50 of the Handbook. This report is approved by the Committee.

I move the adoption of the report.

L. J. GARIEPY, M.D. (Wayne): I second it.

THE CHAIRMAN: Any remarks? All in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Committee on Procurement and Assignment of Doctors of Medicine is printed on page 76 of the Handbook. The Committee approves the report.

Mr. Chairman, I move the adoption of the report.

F. H. DRUMMOND, M.D. (Bay): I second the motion.

THE CHAIRMAN: All in favor, respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Joint Committee with the State Bar of Michigan. The Committee approves the report as printed in the Handbook on page 51.

Mr. Chairman, I move the adoption of the report.

C. A. PAUKSTIS, M.D. (Mason): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: Mr. Speaker, I now move the adoption of the report as a whole.

DR. O'DONNELL (Alpena): I second it.

THE CHAIRMAN: Is there any discussion? All in favor respond by saying "aye"; contrary "no." Carried.

XIII-5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

THE CHAIRMAN: Next is the Committee on Amendments to the Constitution and By-laws. Dr. Hess of Bay.

XIII-5 (a). CONSTITUTIONAL AMENDMENTS PRESENTED IN 1943

DR. HESS: Please turn to page 18 in the Handbook. This is the first amendment to the Constitution. This deals with doctors in medical schools who are called to the Army for military services before they have an opportunity to hang up their shingle and start their private practice. I will read part of the Constitution to show how this subparagraph applies.

XIII-5 (a). CONSTITUTION—ARTICLE III, SECTION 4

Page 81, Article III, Section 4, in the middle of the page:

"Associate Members—County Societies may elect as Associate Members"—(then to subparagraph No. 4) "Physicians not engaging in any phase of medical practice."

Now, the addition of the subparagraph reads this way:

"5. Physicians, residents of the State of Michigan, for the period of time they are in active Military Service of the United States previous to their engaging in active practice."

Mr. Speaker, I move the adoption of this report.

(The motion was seconded)

THE CHAIRMAN: All those in favor, respond by saying "aye"; contrary "no." Carried.

XIII-5 (a). CONSTITUTION—ARTICLE III, SECTION 4

DR. HESS: Amendments No. 2 and No. 3 both cover the same subject and deal with active members who are out of practice because of long standing illness. Again, that applies to Article III, Section 4. and in that case, the county society may elect as Associate members,

"6. Active Members, by transfer, for the period of time they are temporarily out of active practice on account of protracted illness."

The Committee recommends the adoption of Amendment No. 2.

Mr. Speaker, I move the adoption of this resolution. (The motion was seconded.)

THE CHAIRMAN: Is there any discussion? All in favor respond by saying "aye"; contrary "no." Carried.

XIII-5 (a). CONSTITUTION—ARTICLE III, NEW SECTION 8

DR. HESS: Item No. 4. Page 18, bottom of the page: "Amend Article III by adding a new Section to be known as Section 8, to read as follows:"

Now, this deal with life members. The Committee recommends the deletion of item (c). I will read the amendments (a) and (b) as recommended by the Committee:

"Life Members. A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

"The County Society of such member shall make request for certification, in writing, to the Secretary of the State Society thirty days or more in advance of the Annual Session."

The part that is deleted is that this member should not apply or be incorporated in the Constitution until at the Annual Session following the termination of the present World War. The original idea was it would decrease the number of paying members and thus deplete our treasury.

Since last year, I have been able to get a little more information as to probably how many members this would affect, and from the information I have been able to get—however, it is very difficult to determine—I do not think that more than perhaps thirty members would be involved and it would appear that life members of the age of seventy are entitled to payment of their dues and the treasury probably could stand that charge.

Therefore, the Committee recommends the adoption of (a) as read.

Mr. Speaker, I move the adoption of this resolution as revised.

THE CHAIRMAN: We will vote an (a). Is there a second?

L. W. GERSTNER, M.D. (Kalamazoo): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; opposed, "no." Carried.

DR. HESS: Amend Article III, Section 1 by adding to the list of memberships, the following:

"Life Members."

The present Section 1 reads as follows:

"This Society shall consist of active members, honorary members, associate members, retired members, and members emeritus."

Life Members are being added by this resolution.

Mr. Speaker, I move the adoption of this resolution.

J. J. WALCH, M.D. (Delta-Schoolcraft): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; opposed "no." Carried.

XIII-5 (a). CONSTITUTION—ARTICLE VIII, SECTION 2

DR. HESS: No. 5, at the bottom of page 19. Amend Article VIII, Section 2, to read as follows:

"The House of Delegates at each Annual Session shall elect the President-Elect, the Speaker and Vice Speaker of the House of Delegates, and the Councilors. These officers shall be installed in the general meeting at which the reports of the House of Delegates are received. They shall serve until the corresponding time of the next annual session except that the Councilors shall serve for five annual sessions. The terms of the Councilors shall be arranged so that not more than four terms expire normally at any annual session. All these officers shall serve until their successors are elected and take office.

"At the annual session next following his election the President-Elect shall be installed into and assume the office of Presidency immediately following the annual address by the retiring President and shall serve until the corresponding time of the next annual session. This assumption of office shall occur in the general meeting at which the reports of the House of Delegates are received.

"If no general meetings are held at the annual session, then induction into the office of the incoming president and the newly-elected officers shall be in the last meeting of the annual session of the House of Delegates.

"The Secretary, the Editor of THE JOURNAL and the Treasurer shall be elected by the Council in its annual meeting in January of each year. They shall take office immediately and serve for a term of one year or until their successors are elected and take office."

The reason for this proposed amendment was, because in the present constitution, the section states that the President shall be elected each year, which of course is not true. The President retires and the President-Elect fills the vacancy. Also, the time when these officers take office is not very clear and the intent is to specify just when an officer takes his office. This is approved by the Committee.

Mr. Speaker, I move the adoption of this resolution.

THE CHAIRMAN: There is a motion before the House. Do I hear a second?

C. A. PAUKSTIS, M.D. (Mason): I second it.

THE CHAIRMAN: Is there any discussion? If not, all in favor respond by saying "aye"; contrary "no." Carried.

XIII-5 (b). AMENDMENT TO BY-LAWS PRESENTED IN 1943

DR. HESS: Page 20, referring to the Committee on Ethics. This was referred back to the Special Committee last year and was considered in the proposed legislation on procedures on ethics to be taken up and considered this year. That will be taken up in a moment.

XIII-5 (b). BY-LAWS—CHAPTER 8, SECTION 4

The next resolution deals with disabled veterans: (No. 2)

"WHEREAS, Every reputable doctor of medicine under license to practice medicine and surgery and midwifery by authority of the Michigan State Board of Registration in Medicine, is eligible for active membership in a component county society as provided in the Constitution, Article III, Section 2, and By-Laws, Chapter 9, Section 3, irrespective of his being in active practice, although if not in active practice, he may be elected as Associate Member at the option of the component County Society as provided in the Constitution, Article III, Section 4, and

WHEREAS, Active Members, becoming totally disabled while on active duty in the military forces of the United States should have their state dues and assessments remitted, be it

"RESOLVED, That Chapter 8, Section 4 of the By-Laws be changed to read as follows:

"An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately folowing such duty."

This amendment was revised as to wording. Mr. Speaker, the Committee recommends the adoption of this resolution as read and I move the adoption of the resolution.

THE CHAIRMAN: There is a motion before the House.

H. D. DYKHUISEN, M.D. (Muskegon): I don't find the last proposed amendment printed in our Handbook.

DR. HESS: This is pertaining to our By-Laws. Only those pertaining to the Constitution are printed in the Handbook.

DR. DYKHUISEN: We have a proposed amendment to Chapter 6 of the By-Laws, but not this one.

DR. HESS: This was read. This pertains to the By-Laws, not the Constitution. A proposed change to the Constitution must be laid over for one year. The proposed amendments to the By-Laws are referred to the Committee and may be reported on at that same session.

(The motion was seconded.)

THE CHAIRMAN: Is there any further discussion? All in favor respond by saying "aye"; contrary "no." Carried.

XIII-5 (b). BY-LAWS—CHAPTER 6, SECTION 6

DR. HESS: Resolution No. 4.

"RESOLVED, That the name of the 'Committee on Cancer,' as given in Chapter 6, Section 6 of the By-Laws, be changed to the present name of this Committee and read as follows: 'Committee on Cancer Control.'"

I move the adoption of this resolution.

V. N. BUTLER, M.D. (Wayne): I second it.

THE CHAIRMAN: Any discussion? If not, all in favor respond by saying "aye"; opposed? Carried.

DR. HESS: Resolution No. 5.

XIII-5 (b). BY-LAWS—CHAPTER 3, SECTION 7m

"RESOLVED, That Chapter 3, Section 7, paragraph m, first sentence of the By-Laws have the words 'session' and 'meeting' interchanged, so that the first sentence shall read as follows:

"The Election of officers shall be held at the last *meeting* of the House of Delegates at the Annual *Session.*"

The Committee has approved this resolution. Mr. Speaker, I move the adoption of this resolution.

L. J. BAILEY, M.D. (Wayne): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; opposed? Carried.

XIII-5 (b). BY-LAWS—CHAPTER 6, SECTION 5

DR. HESS: Resolution No. 6.

"WHEREAS, It is desirable to clarify the appointment and the length of terms of representatives on the Joint Committee or Health Education, be it

"RESOLVED, That Chapter 6, Section 5 of the By-Laws be revised so that it shall read as follows:

"The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the approval of the Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944, the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term."

The Committee made slight revisions in the wording. Mr. Speaker, I recommend its adoption.

A. E. CATHERWOOD (Wayne): I second it.

THE CHAIRMAN: All those in favor respond by saying "aye"; opposed? Carried.

XIII-5 (b). BY-LAWS—CHAPTER 6, SECTION 7

DR. HESS: Resolution No. 7.

"WHEREAS, The present Committee on Postgraduate Medical Education now consists of twelve members including a chairman and an assistant chairman and the length of the term of a member should be more clearly specified, be it

"RESOLVED, That Chapter 6 Section 7 of the By-Laws have the first paragraph deleted and the following substituted therefor:

"The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the approval of the Council. each member to serve for a three-year term, so staggered that four members are selected annually, provided that in 1944 the term of four members shall be for three years, four for two years and four for one year. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term."

Those of you who have read the By-Laws know the present way is, there are twelve members actually serving on the Committee. That is provided for in the resolution. Also, that the length of terms are not specified, but it is customary for them to serve three terms. This has been approved by the Committee.

Mr. Speaker, I move the adoption of this resolution.

(The motion was seconded.)

THE CHAIRMAN: Was that voted on before? "aye"; opposed? Carried.

XIII-5 (b). ETHICS—BY-LAWS—CHAPTER 9, SECTIONS 3 TO 10 INCLUSIVE; CHAPTER 5, SECTION 4; CHAPTER 6, SECTION 9.

DR. HESS: The last resolution deals with the procedure on ethics. The resolution as presented looks rather simple. I wish to say, we certainly wish the process of writing it were equally as simple. It seems a number of attempts were made to change even one word. It is necessary to reread the entire Constitution and By-Laws to be sure there is no conflict. There was considerable discussion on this resolution.

I will read the resolution as revised by the Committee and then bring up the certain points.

Resolution No. 3.

"WHEREAS, The Council has appointed a Special Committee to make a critical survey of the By-Laws governing the procedures on unethical conduct and to recommend changes for the purpose of clarification and simplification of the procedures, and

"WHEREAS, The present rules provide that a member, disciplined by his component county society, may appeal, first to the Councilor of his District, then to the Council, and finally to the Judicial Council of the American Medical Association, and

"WHEREAS, A dsciplined member should be allowed to appeal directly to the Council, so that the Councilor from his district may sit without prejudice at the hearing on an appeal which such member may make to the Council, and

"WHEREAS, It is desirable to specify the length of term of members of the Committee on Ethics of the State Society and to clarify the duties of the Committee, be it

"RESOLVED, That Chapter 9, Section 3 of the By-Laws have the third sentence of the first paragraph deleted and the procedure on disciplinary action by component county societies amended, so that Section 3 shall read as follows:

"Each component county society shall be the judge of the qualification of its own members, but as such societies are the only portals to this Society and to the American Medical Association, every reputable practitioner of Medicine who meets the requirements specified in the Constitution, Article III, Section 2, shall be eligible to active membership.

"A component county society may expel, suspend, or otherwise discipline a member under such procedure as is specified in its Constitution and By-Laws, provided he is served by registered mail with a written copy of the charges preferred against him, and given at least 30 days' notice of a hearing at which he may offer defense against such charges. He may employ counsel. Efforts at conciliation and compromise shall precede all hearings.

"A member under disciplinary action may appeal to the Council of the State Society. However, such disciplinary action shall remain in effect during the time an appeal is pending. A report of the action taken shall be made by the component county society within 30 days to the Secretary of the State Society."

May I make a few comments on that portion which deals with the officials of the component societies? It is proposed not to limit action and the rights of component societies any more than necessary, and keep it as simple as possible. It is specified a County Society may limit their procedure as specified in the Constitution and By-Laws. It is possible that the counsel for a member may come into a hearing and demand that the rules of the hearing be according to the federal courts and circuit courts and so forth. The rules under which the hearings should be held should be specified in the Constitution and By-Laws and those should prevail.

There are certain provisions here, that this member must be given a written copy of the charges, must be given due notice, and opportunity to defend himself at a hearing. These are so important, if any county society should not permit one of them and if that member appealed either to the counselor or to the judicial council of the American Medical Association, either party may declare a mistrial and refer the case back to the county society.

"BE IT RESOLVED FURTHER, That Chapter 9, Section 4 of the By-Laws be deleted and the following substituted therefor:

"A member of a component county society whose license has been revoked shall be dropped from membership automatically as of the date of revocation."

That is amended in our present chapter as it is here.

"BE IT FURTHER RESOLVED, That Chapter 9, Section 5 of the By-Laws be deleted and the subsequent Sections 6 to 10 be numbered 5 to 9 respectively. Be it further

"RESOLVED, That Chapter 5, Section 2 of the By-Laws have the word 'censor' deleted so that the first sentence shall read as follows:

"Each Councilor shall be the organizer, adviser, and peacemaker for his District.

"BE IT FURTHER RESOLVED, That Chapter 5, Section 4 of the By-Laws be deleted and the procedure on appeal to the Council from disciplinary action be revised, so that Section 4 shall read as follows:

"A member disciplined by his component county society may file an appeal in writing to the Council within ninety days of such dsciplinary order. This appeal shall be referred by the Council to the Committee on Ethics of the State Society for investigation and report. After giving at least thirty days' notice to the appealing member and his component county society the Council shall hold a hearing on the appeal under such rules as it may adopt. The Council shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next ninety days a further appeal may be made to the Judicial Council of the American Medical Association."

This has been the revised wording by the Committee in its present form.

"BE IT RESOLVED FURTHER, That Chapter 6, Section 9 of the By-laws be deleted and the following substituted therefor:

"The Committee on Ethics shall consist of eight members appointed by the President with the approval of the Council, each member to serve for a four-year term, so staggered that two members are selected annually, provided that: In 1944 the term of two members shall be for four years, two for three years, two for two years and two for one year. In case a vacancy occurs before the expiration of a member's term the President shall appoint a successor to serve the unexpired portion of the term.

"The Committee shall render advisory opinions on questions of ethics submitted to it by the Council.

"On request of the Council it shall conduct an investigation, under rules approved by the Council, concerning the ethical conduct of a designated member of this Society and report its findings to the Council."

Now, in the resolution read last night, there is one sentence that has been omitted and that has to do with the apparent conflict with other chapters of the By-Laws. As was brought out last night, that Chapter 1, Section 2, provides that the Council may refer to the House of Delegates this recommendation as to what action should be taken on a charter.

It says here that the charter of any component county society may be revoked by the House of Delegates if, after filing with the Secretary of this Society, a written petition signed by the Chairman of the Council pursuant to a resolution adopted by the Council with the affirmative vote of two-thirds of all the members thereof, and, after due notice of hearing and after hearing, thereof, the House of Delegates by a two-thirds vote of its members decides that the provisions of the Constitution and By-Laws of this Society have been breached, or that such County Society has committed acts or conducted itself in conflict with the Constitution and By-Laws or provisions of this Society to such an extent as to make such revocation desirable in the best interests of this Society.

Now, there is another provision for revoking charters on page 96, Section 6:

"It shall upon application provide and issue charters to county societies organized in conformity with this Constitution and By-Laws and revoke such charters when deemed necessary."

There is a third sentence in the By-Laws that also may apply to some of these proceedings. That is also on page 96, Section 4:

"All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion."

Now, the Committee felt in order that the recommendation of the Council, referring this ethical conduct procedure to the meeting this evening, that it might be discussed, this sentence will be deleted from the proposed change on ethical conduct. Otherwise, it may be interpreted that no discussion of an ethical nature could be permitted on that subject this evening.

Now, of course, procedure is impossible in the discussion coming up this evening. The House of Delegates may refer this matter back to the Council to act in accordance with Section 6, Chapter 5, as given on page 96, "They shall issue charters and revoke such when necessary."

Now, "All unethical conduct shall be referred to the Council without discussion." Then, that matter may be discussed this evening if the House of Delegates so wishes. Then, you may either act on the matter itself or approve it with the Council.

That is the resolution on ethical conduct as read and approved by the Committee.

I move its adoption.

E. T. MORDEN, M.D. (Lenawee): I second it.

DR. HESS: I move the adoption of this report as a whole.

J. A. KASPER (Wayne): I want to call to your attention that part (c) amendment 4 has not been voted. That is on page 19.

DR. HESS: That reads:

"BE IT RESOLVED, That these amendments shall take effect and be incorporated in the Constitution at the Annual Session following the termination of the present World War."

As I mentioned, as to when the present World War will terminate, that is a question for discussion. The Committee recommends this be deleted.

THE CHAIRMAN: Was that voted on before?

DR. GRUBER: I believe the motion was that this not be adopted.

DR. HESS: I would like to present this although I presented the resolution. I think it is correct, but I will make the motion that this item be not adopted.

DR. GRUBER: I second the motion.

THE CHAIRMAN: Any discussion? All those in favor respond by saying "aye"; opposed? Carried.

DR. HESS: I now move the adoption of this report as a whole.

(The motion was seconded.)

THE CHAIRMAN: All in favor respond by saying "aye"; opposed? Carried.

(The Speaker reassumed the Chair.)

THE SPEAKER: With your permission, the Chairman would like to clarify the order of business a little bit. It is now about twelve twenty-three and we are going to stop promptly at one o'clock. There have been requests to accept a motion for one or two resolutions, so we will have to work extra hard. With your permission, we will change the order of business and ask now for resolutions.

VII-5. CHIPPEWA-MACKINAC COUNTY SOCIETY PROBLEM

DR. GRUBER (Wayne): Last evening we were informed by the Council, and I believe, by the Speaker, that at this evening's session, certain information was to be presented to the House regarding a condition that exists in the Chippewa-Mackinack County Medical Society. The House of Delegates are not acquainted in specific terms with what is to be brought to the attention of the House this evening.

I move that a committee be appointed from the members of the House of Delegates to confer with a committee from the Council this afternoon to bring in a report. That would be a fact-finding committee to bring in a report on this subject for the information of the House of Delegates this evening so as to have in concise form what this proposition is and so as to save a lot of time and discussion on a lot of presentations hit or miss at that time.

A. E. STICKLEY, M.D. (Ottawa): I second that motion.

THE SPEAKER: You have heard the motion. Is it perfectly clear that the Speaker of the House will appoint a committee from this House of Delegates to confer with the Committee of the Council to bring in a report on this Chippewa-Mackinac question. That is, a fact-finding committee. It will have no power to act. Is there any discussion? All in favor of this motion say "aye"; opposed? The motion is carried.

The Speaker will make those appointments at this time. A. E. Catherwood, M.D., of Wayne, Chairman; S. L. Loupee, M.D., of Cass; J. S. DeTar, M.D., of

Washtenaw; F. J. O'Donnell, M.D., of Alpena; C. E. Simpson, M.D., of Wayne. Now, may I say, the fact-finding committee is certainly at liberty to confer with anybody else on the Council or anyone else who can give them information in addition to the committee appointed by Dr. Moore. I am sure most of the committee are pretty familiar with the affair and will be glad to discuss it with you.

THE SPEAKER: This change in the order of business was for a specific purpose. We will recognize Dr. Breakey.

R. S. BREAKEY, M.D. (Ingham): This is in lieu of information just received this morning.

VIII-12. CONSULTATION SERVICE OF UNIVERSITY OF MICHIGAN HOSPITAL

Resolution No. 32 was presented by Dr. Breakey of Ingham County.

There has been reported the adoption of a policy by the administration of the University Hospital to the effect that the staff of the hospital submit reports of findings of patients and further advice relative to treatment of such patients to osteopaths and

WHEREAS, the University Hospital constitutes an integral part of the University of Michigan Medical College a pre-eminent institution in medical education and

WHEREAS, if true that such consultation reports or advice is furnished to osteopaths it would appear to constitute recognition of osteopathy by this leading institution of medical teaching and science and to possibly thus undermine the dignity and prestige of its own graduates of medicine. Therefore be it

RESOLVED, That The Council be instructed to ascertain from the administration of the University Hospital the facts concerning his question and if as reported to urge the cessation of such practices.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

We shall go on then to the reports of the Reference Committee on Resolutions and we will not have time to finish that. However, we will work to approximately one o'clock.

Dr. Brasie of Genesee.

XIII. REPORT OF REFERENCE COMMITTEE

XIII-6. ON RESOLUTIONS

DR. BRASIE: Your Reference Committee on Resolutions met last evening with all members present.

We ask the privilege of the Chair to present some of these resolutions to you slightly differently inasmuch as there is quite a bit to do and there were a great number of men up for membership emeritus and otherwise. With your permission, sir, if there is no complaint from the floor, we will present them as a group.

THE SPEAKER: Is that agreeable to the House? (Agreed.)

XIII-6 (a). SPECIAL MEMBERSHIPS

DR. BRASIE: Your Reference Committee on Resolutions approved all the various resolutions presented re special memberships: briefly, to enumerate the names submitted:

Membership Emeritus: William A. Lathrop, M.D., E. C. Warren, M.D., Emil Amberg, M.D., William Kerr, M.D., Nancy Rodger Chenoweth, M.D., Henry G. Merz, M.D., G. F. Brewington, M.D., W. T. S. Gregg, M.D., David H. Burley, M.D., and Arthur Grigg, M.D.

Retired Members: Paul Roth, M.D., George M. Livingstone, M.D., Bertha Moshier, M.D., J. Holes, M.D., and V. L. Tupper, M.D.

Affiliate Fellowship in A.M.A.: V. L. Tupper, M.D.

Mr. Speaker, I move the adoption and acceptance of this portion of the report.

J. J. O'MEARA (Jackson): I second it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed? The motion is carried.

I would like to interrupt you for one minute. Dr. Moore, the Chairman of the Council, has appointed a committee as follows: He has not named the chairman so I imagine he means the first name to be that of the chairman. These are the members of the Council who will be on the Council Committee to meet with the fact-finding committee just appointed by the Speaker. C. E. Umphrey, M.D., A. H. Miller, M.D., O. O. Beck, M.D., R. S. Morrish, M.D.; Wm. Barstow, M.D., L. F. Foster, M.D., as Secretary.

Now, Dr. Brasie.

DR. BRASIE: On the resolution concerning the centenary of anesthesia, the Committee deleted the name of Dr. Horace Wells of Hartford, Connecticut, and changed the resolution slightly and we offer this as a substitute resolution. I will read it first in its original form. Resolution No. 27.

XIII-6 (b), ENDORSING CENTENARY OF NITROUS OXIDE ANESTHESIA

"WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide by Dr. Horace Wells of Hartford, Connecticut, therefore be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society commends and endorses the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia by Dr. Horace Wells of Hartford, Connecticut.

There was considerable discussion and some comments as to the fact it was not completely agreed as to who really did first discover this and should take the credit for it. We wish to back up the Society of Anesthetists, and not wishing to have any controversy, we offer the changed resolution as follows:

"WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide, therefore be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society commends and endorses the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia by the Michigan State Society of Anesthetists."

Mr. Speaker, I move the adoption and acceptance of this report.

F. G. BUESSER, M.D. (Wayne): I second it.

THE SPEAKER: Any discussion? All in favor say "aye"; opposed? Carried.

XIII-6 (c). SELECTIVE SERVICE FOR MEDICAL STUDENTS

DR. BRASIE: Resolution No. 15 submitted by Dr. Pino, and entitled "Selective Service for Medical Students."

"WHEREAS, a recent Selective Service ruling provides that there shall be no deferments for pre-medical and medical students not enrolled in medical schools by July 1, 1944.

"WHEREAS, This ruling will reduce entering classes in 1945 by about 30 per cent, thus drastically curtailing medical classes,

"WHEREAS, Many such pre-medical and medical students would necessarily be physically disqualified men or women,

"WHEREAS, It is obvious that the number qualified would be entirely inadequate to meet the needs of medical care in this country during the next decade,

"WHEREAS, Many young medical officers will be detained in the army and navy and air corps for some time following the war, thus adding to the deficit.

"WHEREAS, Appeal to the army and navy and President of the United States by the AMA have been unproductive of results, be it therefore

"RESOLVED, That an appeal be made directly to the members of Congress from Michigan by the Michigan State Medical Society urging these members of Congress to take cognizance of a situation that inevitably will reduce the numbers of doctors of medicine in the United States to the point where medical care will be reduced far below necessary standards required to maintain safety of health care not alone from the standpoint of contagion but in all other aspects of health, and be it further

"RESOLVED, That the office of the Society implement this resolution."

This resolution was approved as read.

Mr. Chairman, I move the acceptance and adoption of this resolution.

C. E. SIMPSON (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? Carried.

(To be concluded in February issue)

Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

RECOMMENDATIONS FOR CONTROLLING SCALP RINGWORM

1. We advise health officers and school physicians to make a survey of all schools in communities where cases of scalp ringworm are known to exist.
2. The simplest way to make a clinical diagnosis is with the use of a Wood filter.
3. The best method of treatment known at the present time for the form of ringworm now existing in the state is epilation by means of x-ray and subsequent treatment with a suitable fungicide. Parents are warned that x-ray treatment of ringworm of the scalp may be dangerous unless given by a competent radiologist who is trained in this method of therapy.
4. All measures that are known or believed to prevent the spread of this infection should be introduced—sterilization of all instruments used in barber shops and beauty parlors; avoidance of the interchange of caps by children; disinfecting or otherwise treating the backs of theater seats; and other measures.
5. Exclude from school only children with massive scalp infections.
6. Children with minor or moderate infections may remain in school, provided they are under competent medical care. We advise that all children while in school or other public places whether infected or not, wear caps made of cloth, paper or other material that can be burned or cleaned daily. Segregation of children with ringworm within the school may be an additional safeguard.
7. Parents and teachers should be informed as to the best procedures known, both for the prevention and treatment of ringworm infections.
8. Children who, for financial or other reasons do not consult a physician should be referred to a clinic in which facilities are provided for diagnosis and treatment.

MORE MEDICAL CARE PLANS

Iowa, Kansas, Missouri and New Hampshire recently approved the establishment of nonprofit plans for voluntary prepayment medical and surgical bills.

States in which medical plans previously were established are: Michigan, California, Colorado, North Carolina, Delaware, New Jersey, Pennsylvania, Massachusetts, and New York.

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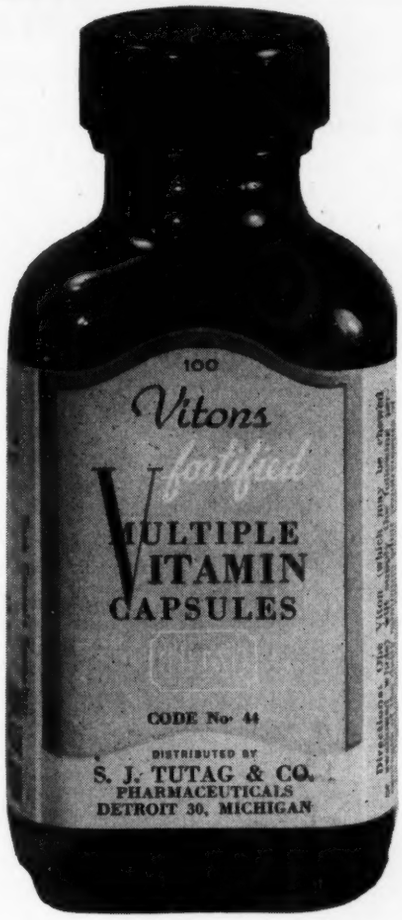

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Vitamin B6 (Pyridoxine Chloride USP) 50 micrograms ..... .050 milligrams

Calcium Pantothenate Dextrorotatory 1000 micrograms .....1 milligram

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Niacinamide USP..... 20 milligrams

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Woman's Auxiliary

THE NEW YEAR

The beginning of the New Year is a time to glance briefly backward; then, to look ahead, chart a new course and go courageously forward. Our backward glance assures us that we have grown steadily through the years, have gained the strength of efficient organization and the confidence of our parent—the MSMS. Our forward glance sees the new problems ahead, the threat of legislation that may change the practice of medicine from a glorious profession to a political plaything.

Now is the time to use our strength, as an organization and as individuals, to fight this threat. Go forth, tell each and every American of the advantages he now has and would lose—the right to choose his own doctor, to change his doctor, to receive medical care *when* he wants it. Remind him that by joining Michigan Medical Service he will ease his financial burden even more than socialized medicine would. The taxation under the latter system would be greater than the cost of medical care to the average member of MMS.

Let every day see us doing something to further the cause of a free medicine and may the New Year bring the struggle to a glorious conclusion.

(Mrs. H. L.) Lela W. French
President

EXECUTIVE BOARD MEETS

The mid-year Executive Board Meeting of the Woman's Auxiliary to the Michigan State Medical Society was held Wednesday, November 29 at 12:30 P.M. at the Wayne County Medical Society Headquarters, Detroit. Twenty-eight were in attendance.

Mrs. H. L. French of Lansing, state president, presided at the meeting. Mrs. L. C. Harvie of Saginaw, president-elect and Mrs. French reported on the National mid-year meeting held in Chicago, November 16 and 17. Discussants included, Mrs. Guy Kiefer, honorary president, East Lansing and Mrs. John J. Walch, past president, Escanaba.

Mrs. T. Grover Amos, program chairman, had a very neat and compact kit for county presidents. Mrs. Amos is also the Auxiliary Convention Chairman for the Annual Session of September 19-20, 1945 at the Statler Hotel, Detroit.

Mrs. M. Shaw, radio speech contest chairman, stated that forty-eight schools from twenty-three counties had participated this year, five new counties entered.

Mrs. Roger Walker, Mrs. J. E. McIntyre, and Mrs. Oscar Stryker comprise the Nominating Committee.

The county presidents reported on their meetings so far and some reported plans for the whole year. *Jackson County* again sent Christmas boxes to thirty-eight doctors in service.

Kent County had a rummage sale and bridge tea, one outstanding meeting was a book review "Who Walks Alone." They have found it very interesting to read letters from members away with their husbands who are in service.

Midland County had a rummage sale for benefit of hospital.

St. Clair County Auxiliary joined with the County Medical Society for dinner where approximately 300 outstanding leaders in the county heard Professor Floyd Armstrong give an address, "What Price Security."

Wayne County sent gifts to Percy Jones General Hospital. They are also having a Hobby Show with the doctors.

Mrs. Galen Ohmart, war service chairman, stressed the need for recruitment for Cadet Nurses.

Mrs. D. M. Kane, *Hygeia* chairman, suggested a plan for increasing subscriptions to *Hygeia*.

Mrs. Sherman Andrews, legislative chairman, has sent material to each county president; she would like a report from county legislative chairmen.

Mrs. W. L. Sherman, Wayne County Auxiliary president, made the arrangement for the luncheon at noon and also entertained the group after the board meeting at her home in the Art-Center Apartments.

* * *

Bay County

Mrs. J. Norris Asline entertained twenty-four members of the Medical Auxiliary at her home in Essexville, at a dessert meeting, with Mrs. C. L. Hess, president, presiding.

Mrs. Laura Dewey, executive secretary of the Bay County chapter of the American Red Cross spoke on "Returning Veterans—Physical, and Psychological Angles."

The rooms were decorated with bowls of yellow chrysanthemums. Hostesses were Mrs. P. R. Urmston, Mrs. J. W. Gustin, Mrs. D. E. Siler, and Mrs. Robert Hall.

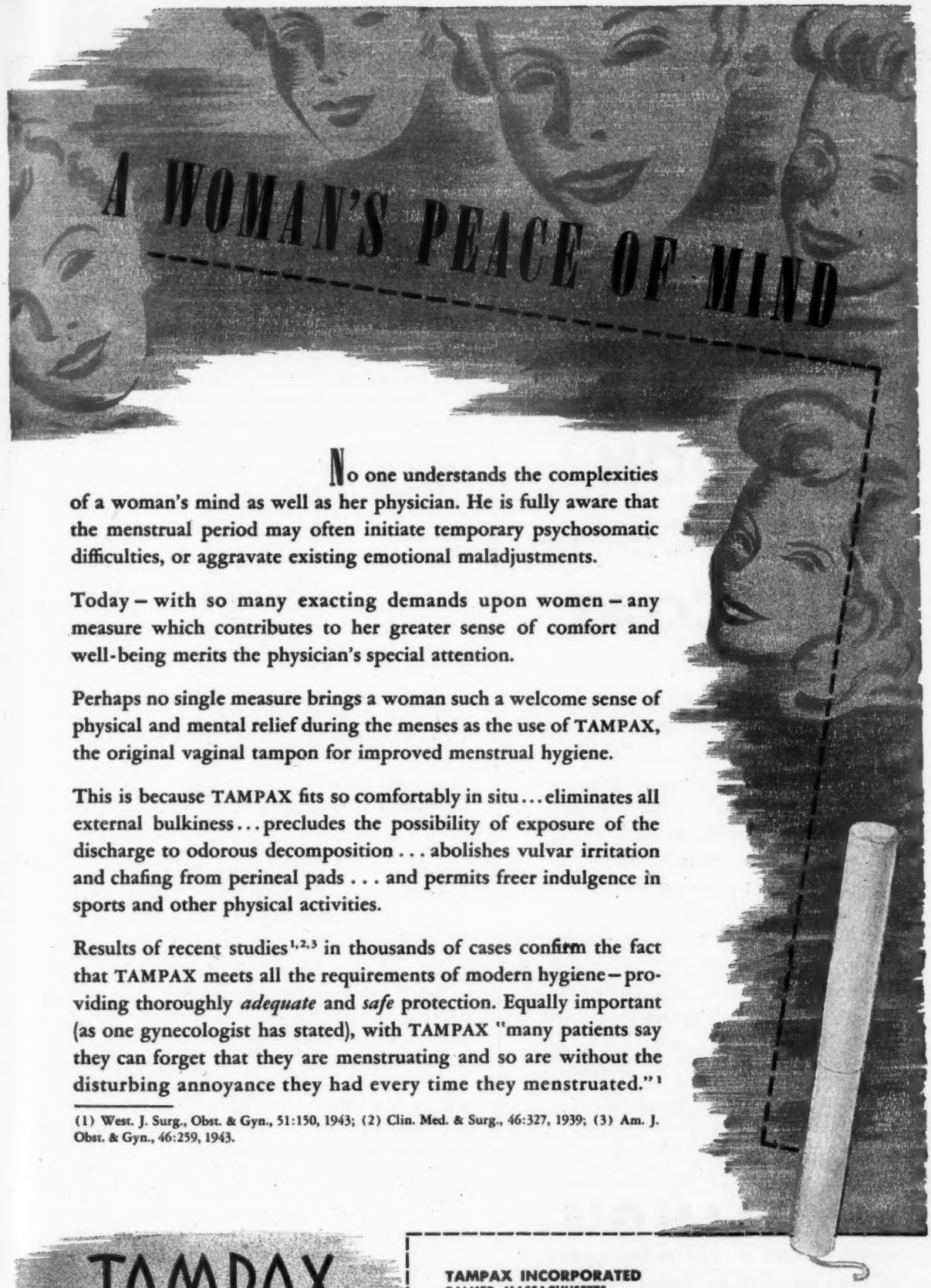
* * *

Wayne County

The Woman's Auxiliary to the Wayne County Medical Society had a very unusual program meeting on Friday, November 10. Luncheon at 12:30 was followed by the meeting at 2:00 P.M. The program was held in the Alger House and was a panel discussion on "Youth Problems in a Large City."

Mrs. Warren B. Cooksey acted as Moderator. Speakers included D. J. Healy, Judge of Probate, Juvenile Division, Wayne County: Miss Eleanore Hutzal, Chief of Woman's Division, Detroit Department of Police; Rev. Frederick Olert, First Presbyterian Church, and Prof. Earl Kelley, Wayne University.

The Ways and Means Committee sponsored a games party in the Auditorium of Providence Hospital on November 18.



No one understands the complexities of a woman's mind as well as her physician. He is fully aware that the menstrual period may often initiate temporary psychosomatic difficulties, or aggravate existing emotional maladjustments.

Today – with so many exacting demands upon women – any measure which contributes to her greater sense of comfort and well-being merits the physician's special attention.

Perhaps no single measure brings a woman such a welcome sense of physical and mental relief during the menses as the use of TAMPAX, the original vaginal tampon for improved menstrual hygiene.

This is because TAMPAX fits so comfortably in situ... eliminates all external bulkiness... precludes the possibility of exposure of the discharge to odorous decomposition... abolishes vulvar irritation and chafing from perineal pads... and permits freer indulgence in sports and other physical activities.

Results of recent studies[1,2,3] in thousands of cases confirm the fact that TAMPAX meets all the requirements of modern hygiene – providing thoroughly *adequate* and *safe* protection. Equally important (as one gynecologist has stated), with TAMPAX "many patients say they can forget that they are menstruating and so are without the disturbing annoyance they had every time they menstruated."[1]

(1) West. J. Surg., Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943.

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In Memoriam

R. S. Buckland of Baraga was born September 28, 1866 in Paxton, Illinois and was graduated from the Fort Wayne Medical College in 1892. After graduation he located at Ewen. After practicing at Ewen and Trout Creek for eight years, he went to Baraga, where he served the community for forty-four years. During his early practice in the north country, Dr. Buckland experienced all the hardships legendary to "a country doctor"; in later years, he was recognized for his excellent results with bone injuries. He was on the staff of St. Joseph's Hospital, Hancock. Dr. Buckland not only rendered great service in his professional work but always took an active part in civic affairs and contributed generously to the growth and development of the Copper Country. He died Oct. 13, 1944.

* * *

Hugo Erichsen of Birmingham was born June 22, 1860 in Detroit and was graduated from the University of Vermont College of Medicine, and the Detroit Medical College. From the Royal College of Physicians and Surgeons of Kingston, Ontario, he received the degree of L.R.C.P. and S. in 1883 and later in life Wayne University conferred upon him the honorary degree of Doctor of Letters. From 1884 to 1886 he was professor of neurology in the medical department of Chaddock University, of Quincy, Illinois. In the course of his lengthy career he was assistant editor of the Detroit Clinic in 1882 and was City Physician from 1888 to 1890. From 1898 to 1918 he was on the editorial staff of Parke, Davis and Company; then director of Medical service for the Burroughs Adding Machine Company from 1918 until 1926. Doctor Erichsen retired to Birmingham where he continued his literary work until the time of his death, October 10, 1944.

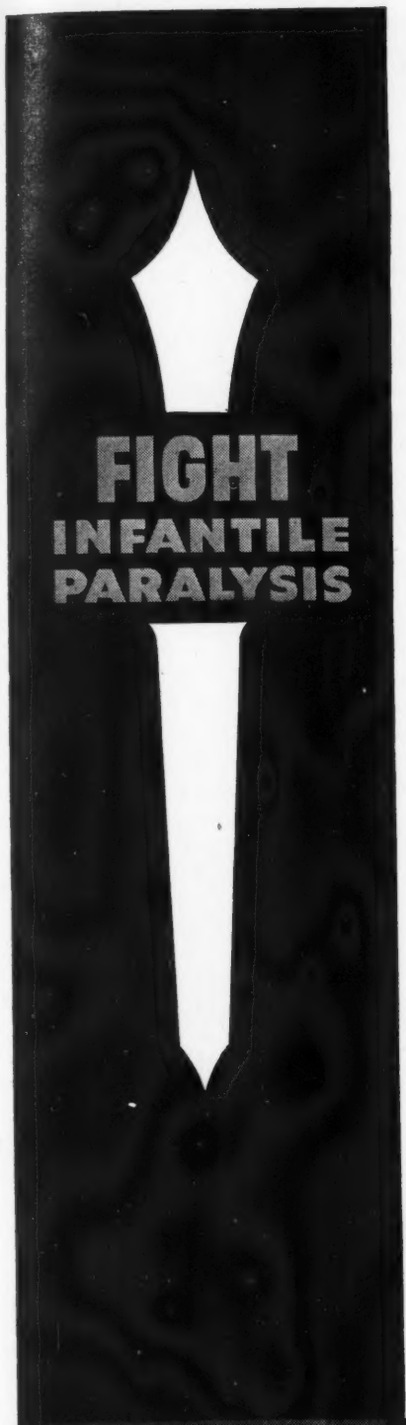
* * *

Robert McGregor of Saginaw was born January 23, 1861, in Glasgow, Scotland, and was graduated from the University of Michigan medical school in 1894. He studied at the universities of Edinburgh, Glasgow and London before coming to America. Doctor McGregor was a neurologist and psychiatrist and in the early months of selective service served as a psychiatrist for the local draft board in Saginaw. Too old for active service in World War I, he returned to the British Isles voluntarily to serve in London hospitals. He was one of Saginaw's oldest practicing physicians. Doctor McGregor died after a brief illness October 31, 1944.

* * *

Rush McNair of Kalamazoo was born July 1, 1860, in Blackberry Station, Illinois and was graduated from Northwestern University Medical School in 1887. Following graduation he located in Kalamazoo. In 1889, Doctor McNair performed the first appendectomy in

(Continued on Page 94)



FIGHT INFANTILE PARALYSIS

This plea keynotes the great humanitarian struggle waged unceasingly by the National Foundation for Infantile Paralysis since its inception in 1938 . . . and climaxed each January by an intense public awareness and support campaign.

The vast scope of the battle against infantile paralysis — involving the time, skill and knowledge of our finest doctors and scientists — cannot be comprehended by the majority of people. However, so deep is the desire of Americans to see the obliteration of this dread disease, that they have to date contributed millions of dollars through annual March of Dimes appeals for research purposes alone.

Recognizing the importance of the work of the National Foundation, Rexall Drug Stores proudly join with the American people in support of the 1945 March of Dimes, January 14—31.

UNITED DRUG COMPANY

Boston • St. Louis • Chicago • Atlanta
San Francisco • Los Angeles • Portland
Pittsburgh • Fort Worth • Nottingham • Toronto

PHARMACEUTICAL CHEMISTS—MAKERS OF TESTED-QUALITY PRODUCTS FOR MORE THAN 41 YEARS

Rexall DRUGS

IN MEMORIAM

(Continued from Page 92)

Southwestern Michigan and perhaps in Michigan, when it was considered fatal to open the abdominal cavity. Medical men of that day held that with this feat he opened the field of abdominal surgery. In 1903 Doctor McNair studied surgery under some of the most noted medical men of that time in Edinburgh. In 1926 Doctor McNair was president of Kalamazoo Academy of Medicine. In later years he prepared and wrote with great enthusiasm his, "Medical Memoirs of Fifty Years in Kalamazoo"—a work which was valuable both as interesting reading and as a source of much historical and biographical information about this section of Michigan. He had recently reopened his offices in the McNair block to begin his fifty-eighth year of practice in Kalamazoo. He died after a brief illness, October 16, 1944.

* * *

James Mitchell of Gladstone was born February 10, 1870 in Kingston, Ontario and was graduated from Queen's University Faculty of Medicine in 1899. Going to Gladstone upon graduation, he remained there briefly and then removed to Saskatchewan, Canada. After a year in Saskatchewan, he returned to Gladstone and was engaged in the practice of medicine there since the turn of the century. Doctor Mitchell was not only one of the senior practitioners of medicine in Delta County, but in addition took an active part in his community activities. He served for thirteen years as a member of the Gladstone Board of Education, heading the body for a time as president. He had been city health officer since 1935. Doctor Mitchell died after a week's illness, October 20, 1944.

* * *

Alexander L. Turner of Detroit was born July 25, 1883 in Eatenton, Georgia and was graduated from the University of Michigan medical school in 1905. He served his internship at Freedman's Hospital in Washington, D. C. and immediately began his practice in Detroit. Later he became a member of the staffs of Women's Hospital and Grace Hospital. He was one of the founders and organizers of the Dunbar Memorial Hospital and an active worker in the building of the St. Antoine Branch YMCA. He died at Ravenna, Ohio, on August 12, 1944.

What's What

Personals

George J. Curry, M.D., Flint, presented a paper on "Principles in Management of Simple and Compound Finger Fractures—Amputations" at the annual postgraduate course in Industrial Medicine and Surgery, held at Long Island College of Medicine, Brooklyn, in October.

* * *

The weekly staff conference at Percy Jones General and Convalescent Hospital, Battle Creek, during December, included: December 4—"Some Aspects of Chemotherapy" by Gordon B. Myers, M.D., Detroit; December 11—"Acute Suppurations of the Mouth, Throat and Neck" by A. C. Furstenberg, M.D., Ann Arbor; December 18—"Symposium on Convulsive Disorders" by Major I. L. Turow, Major Frank H. Mayfield and Lt. D. B. Foster.

The January talks were as follows: January 8—"Urology in General Practice" by Edward M. Cook, M.D., Rochester, Minn.; January 15—"Newer Approaches in the Field of Hematology" by Major Sylvan E. Moolten, Captain W. E. Peltzer, and Miss Edna Keller, Battle Creek; January 22—"Skeletal Traction with Crutchfield Tongs for Spinal Injuries" by W. Gayle Crutchfield, M.D., Charlottesville, Va.; January 29—"Discussion of Pituitary Pathology" by Major G. R. Joyner, Assistant Chief of Medical Service, Battle Creek.

* * *

F. L. Rector, M.D., Lansing, Cancer Consultant of the Michigan State Medical Society and the Michigan Department of Health, gave the principal address at the annual meeting of the Cleveland and Cuyahoga County, Ohio, Field Army Against Cancer on December 5. His subject was "The Why, What and How of Cancer Control."

* * *

Clarence H. Snyder, M.D., Grand Rapids, represented the Michigan State Medical Society on the Physical Rehabilitation Panel arranged on the occasion of the Annual Meeting of the Michigan Society for Crippled Children and Disabled Adults, Grand Rapids, November 17.

* * *

Secretary L. Fernald Foster, M.D., Bay City, was guest speaker at the North Central Medical Conference,

(Continued on Page 98)

Saint Paul, December 10. His subject was "Prepay Medical Service," and included a report on Michigan Medical Service.

* * *

A. B. Gwinn, M.D., Hastings, Michigan, had an article published in the *American Journal of Surgery,* entitled "Gas Gangrene Treated with Sulfathiazole and Zinc Peroxide," pages 430 to 433, September, 1944. The article is illustrated with several radiographs of hands showing the involvement and treatment.

* * *

Honors

D. J. McColl, M.D. of Port Huron was honored by the Port Huron Kiwanis Club for his fifty-one years of practice as a physician in Port Huron and twenty-five years of service with the Kiwanis Club. Kiwanis presented Dr. McColl with a certificate of life membership for distinguished service to Kiwanis and to his community. Congratulations Dr. McColl!

* * *

Michigan Physician Army Officers who have been promoted from Major to Lieutenant Colonel include the following: John Merton Schonfeld, Bloomfield; G. Howard Gowan, Ann Arbor; Theodore Henry Pauli, Pontiac; Leslie Frank Wilcox, Grosse Point Farms; Clifford Wesley Colwell, Flint.

* * *

Captain Mark W. Dick, MC, of Grand Rapids, has received the bronze star for bravery under fire. His citation declares that "on March 12, 1944, at Bougainville, Solomon Islands, while enemy mortar shells exploded around him, he ran 40 yards and crawled under a barbed wire entanglement to reach a seriously wounded soldier. Finding that the nature of the man's wounds made it impossible to move him to the protection of a pillbox, he unhesitatingly exposed himself and stood in an upright position to administer medical treatment during the intense mortar barrage."

* * *

The American College of Surgeons announces that the following Michigan physicians were accepted into Fellowship of the ACS in 1944: John H. Albers, M.D., Detroit; Ralph M. Burke, M.D., Port Huron; Fleming A. Barbour, M.D., Flint; Matthew C. Bennett, M.D., Detroit; Robert W. Buxton, M.D., Ann Arbor; George E. Chittenden, M.D., Detroit; Clinton L. Compere, M.D., Grand Rapids; Peter Crabtree, M.D., Ann Arbor; Robert T. Crowley, M.D., Detroit; Fillmore S. Curry, M.D., Detroit; David M. Davidow, M.D., Detroit; A. Edward Drexel, M.D., Detroit; Paul W. DuBois, M.D., Detroit; Owen C. Foster, M.D., Detroit; Joe H. Gardner, M.D., Detroit; James L. Gillard, M.D., Muskegon; Cameron Haight, M.D., Ann Arbor; John E. Hauser, M.D., Detroit; Willet J. Herrington, M.D., Bad Axe; Moses J. Holdsworth, M.D., Grand Rapids; Benjamin F. Hoopes, M.D., Detroit; Reader J. Hubbell, M.D., Kalamazoo; Donald J. Jaffar, M.D., Detroit; Harry N. Jurow, M.D., Detroit; Earl B.

(Continued on Page 100)

Kay, M.D., Ann Arbor; Hugh M. Mahoney, M.D., Detroit; John E. Manning, M.D., Detroit; Jerome Mark, M.D., Detroit; Earl G. Merritt, M.D., Detroit; Hazen L. Miller, M.D., Detroit; Arthur K. Northrop, Jr., M.D., Detroit; James W. O'Dell, M.D., Detroit; Harold A. Ott, M.D., Detroit; Brue Proctor, M.D., Detroit; Alton E. Pullon, M.D., Kalamazoo; Henry W. Sill, M.D., Jackson; D. Emerick Szilagyi, M.D., Detroit; William L. Valk, M.D., Ann Arbor.

* * *

AMA Session Cancelled

The American Medical Association will not hold its Annual Meeting in 1945, according to word received in January from Olin West, M.D., Secretary.

* * *

Coming Meetings

Doctor, you are cordially invited to attend the Annual Clinical Conference of the Chicago Medical Society, Palmer House, Chicago, February 27-28 and March 1, 1945. The program will be of interest to all physicians, general practitioners and specialists alike.

This Conference represents an opportunity for three days of intensive postgraduate medical education. Hotel reservations should be made at once.

* * *

Mt. Carmel Mercy Hospital will hold its Annual Clinic Day on Wednesday, January 31. Outstanding speakers will be on this program. A complimentary luncheon will be served all registrants in the Hospital at 1:00 p.m.

All members of the Michigan State Medical Society are cordially invited to attend this Clinic Day at Mt. Carmel Mercy Hospital, located at 6071 W. Outer Drive, Detroit.

* * *

Statistics

Michigan Medical Service.—Of each dollar received by Michigan Medical Service, 79 per cent goes to physicians for services, 12% for administration, and 9% into the reserve fund.

* * *

How much is a billion? Well, for example, if you lived a billion minutes, you would reach the ripe old age of 1,903 years; and to accumulate a billion dollars (not including interest) you would have to earn a dollar a minute since the year 41 A. D., or $525,600 a year for 1,903 years.

The national debt—before the end of the war—may be 300 billion dollars!

A program for retiring the national debt at a rate of 1 per cent annually over a period of 100 years would represent an annual payment of three billion dollars for retirement of the debt and six billion dollars a year for interest payments, a total expenditure of the Federal Government for debt alone of nine billion dollars annually!

* * *

The postwar reserve fund of the State of Michigan has reached $47,000,000, and may be increased to $50,000,000 before the end of the year.

(Continued on Page 102)

If You Move, Inform Us at Once of Your New Address

If you change your address please notify THE JOURNAL promptly. The deadline for address changes for each issue is the 10th day of the month preceding date of publication, i. e., 10th day of January for the February issue. If you move, therefore the only way to be sure of getting your JOURNAL regularly is to send your new address in immediately.

If your JOURNAL is late in reaching you these days, please be patient. The mails are clogged and there is a shortage of labor at our print shop. Wait until the 20th of the month before assuming your JOURNAL has gone astray. If you don't get it by then, drop us a line and we will mail you a copy, if extra copies are available.

Incidentally the State Treasury has retired the last of the $50,000,000 bond issued twenty years ago to launch the construction of modern automobile highways in Michigan.

* * *

$34,000 in war bonds as prizes will be given for the best art works of physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty," in war and in peace. This prize contest is open to any physician member of the American Physicians Art Association. For further information write Mead Johnson & Co., Evansville, Indiana.

* * *

Civilian enrollment at the fifty-six Michigan colleges and university has declined one-third during the war period, from 67,220 in 1941 to 47,427.

* * *

The Michigan Civil Service Commission reported that state salaries average $182.50 a month today, compared to an average of $126.92 a month in 1941. If 1944 wages were paid to the 1941 number of workers, the cost would be $10,000,000 more than it actually was in 1941. There are 3,733 less employes now than in 1941.

* * *

Wayne University of Detroit has submitted a request for state aid to the Michigan Planning Commission, pointing out that it has become a large institution of general service to Michigan. The Wayne memorandum states that almost as many physicians practicing in Michigan are graduates of Wayne as are graduates of the University of Michigan School of Medicine.

* * *

A total of 83,544 babies were born in Michigan during the first nine months of 1944.

* * *

Good Reading

Recommended for physicians' reading: "Economic Liberalism and Free Enterprise" by Benjamin L. Masse,

(Continued on Page 104)

reprinted from *America,* 7 E. 45th St., New York 17, New York.

* * *

"Principles of a Nationwide Health Program." This editorial which appeared in JAMA of November 4, 1944, Page 640, is an article that should be read by every member of the Michigan medical profession.

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Miscellaneous

Information on the so-called "Academy-International of Medicine and Dentistry," of 509 Minnesota Street, Saint Paul, Minnesota, may be obtained by contacting the Michigan State Medical Society, 2020 Olds Tower, Lansing 8.

* * *

County Medical Society Elections

The following Adrian physicians were recently elected as officers of the *Lenawee County Medical Society:*

President: Esli T. Morden, M.D.
Secretary: Thomas H. Blair, M.D.
Vice President: Leo J. Stafford, M.D.
Delegate: Esli T. Morden, M.D.
Alternate: Thomas H. Blair, M.D.

* * *

At the November meeting of the *Jackson County Medical Society* the following were elected as officers:

President: E. A. Thayer, M.D., Jackson
President-Elect: Frank Van Schoick, M. D., Jackson
Secretary: H. W. Porter, M.D., Jackson
Delegates: J. J. O'Meara, M.D., Jackson and Corwin S. Clarke, M.D., Jackson
Alternate Delegates: C. R. Dengler, M.D., Jackson and J. D. Van Schoick, M.D., Hanover

* * *

New officers of the *Clinton County Medical Society* elected at the December meeting of the County Society are:

President: B. R. Elliott, M.D., Ovid
Vice President: C. T. Foo, M.D., St. Johns
Secretary-Treasurer: T. Y. Ho, M.D., St. Johns
Delegate: W. B. McWilliams, M.D., Maple Rapids
Alternate: A. C. Henthorn, M.D., St. Johns

CORRESPONDENCE

December 5, 1944

L. Fernald Foster, M.D.
Secretary the
Michigan State Medical Society
2020 Olds Tower
Lansing, Michigan

Dear Doctor Foster:

Your kind communication informing me of my election to Emeritus Membership in the State Society has touched me deeply.

I only tried to do my duty as I saw it.

May I express to the Society my cordial thanks for the high honor of which I am very conscious, and for the good wishes extended to me. It is a great satisfaction to learn that one is understood during one's lifetime.

Most sincerely yours,

(Signed) EMIL AMBERG
Detroit

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

TRICHINOSIS. By Sylvester E. Gould, M.D., D.Sc., Pathologist and Director of Laboratories, Eloise Hospital, Eloise, Michigan; Assistant Professor of Pathology, Wayne University College of Medicine, Detroit. Springfield, Ill.: Charles C. Thomas, 1945. Price $5.00.

One of our Michigan doctors has given us a valuable monograph on trichinosis. He discusses the history of trichina, the discovery by various ones and the increasing knowledge of the disease. The morphology and life cycle of the parasite is given, the epidemiology and pathology of the disease. Laboratory methods of study are given in detail, also a discussion of the symptomology and treatment. The treatment is non-specific, and the mortality varying from zero in two epidemics involving 200 cases to one of 30 per cent of 337 cases. The average is around 10 per cent. This is an authoritative text, full of material, with a bibliography beginning with Tiedemann in 1822, and ending with many citations in late years. The practicing physician, the public health worker, the laboratory man must have this work to understand the increasing numbers of persons infected with this disease.